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Original Article

Refugees, Migrants and Universal Health Coverage in Iran: Access Challenges and Policy Options

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Abstract:

Introduction: Refugee and migrant populations are increasing globally, intensifying the need for equitable access to essential health services and progress toward universal health coverage (UHC). Iran hosts large numbers of documented and undocumented refugees and migrants, yet barriers may limit access to care. This debate article aims to synthesize Iran-specific evidence on access challenges and to outline feasible policy options to advance migrant-responsive UHC.

Methods: We conducted an evidence-informed narrative synthesis of Iran-focused peer-reviewed studies and relevant policy/technical documents identified through targeted searches of PubMed, Scopus, and Web of Science, supplemented by reference-list screening and key WHO/UNHCR and national materials. We focused on four domains with comparatively robust Iran-specific evidence and high UHC relevance: primary health care, maternal care, HIV services, and rehabilitation.

Results: Across domains, recurring barriers included language and communication difficulties; cultural mismatches; limited or incomplete insurance coverage and high out-of-pocket payments; low health literacy and unfamiliarity with the health system; stigma and discrimination (particularly in HIV services); and financial and geographic constraints that disrupt continuity of care. Legal status insecurity—especially among undocumented migrants—further delays care-seeking and follow-up. Policy options include expanding affordable insurance with flexible premium payment; strengthening culturally competent care and interpreter support; targeted health-literacy outreach and service navigation through NGOs/community actors; stigma-reduction training and confidentiality safeguards; and subsidised referral pathways for specialised services, including rehabilitation.

Conclusion: Coordinated reforms in financing, culturally responsive service delivery and community-based support can improve access for refugees and migrants and accelerate progress toward UHC in Iran.

Keywords: Refugees; Emigrants and Immigrants; Health Services Accessibility; Universal Health Coverage; Iran

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Introduction

Forced displacement and international migration have reached historically high levels, increasing pressure on health systems to deliver equitable access to essential services (1). In 2024, the total displaced population reached 122.6 million, and the world refugee population grew to 43.7 million by mid-2024. Considering the ongoing trend of rising migration and examining the ratio of migrants to the global population, which has varied between 2% and 3.5% over the last fifty years, it is anticipated that by 2050, the number of international migrants will attain 379.6 million, representing 3.9% of the world population (2, 3).

Given the significant increase in the population of refugees and migrants worldwide, providing healthcare services and universal health coverage to them is essential to prevent health crises and improve the quality of life for these individuals (4). Additionally, one of the goals of the World Health Organization (WHO) is to ensure universal access to health services for all individuals (5). In this article, we operationalize universal health coverage (UHC) in line with WHO as ensuring that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship (6).

According to recent global reports, the global average of the universal health coverage index reached 68% by 2022, and in the last decade, less than a third of the world's countries have made significant progress in expanding health services (7). One of the main reasons many countries fail to achieve universal health coverage and the existing health inequalities is the encounter of vulnerable social groups, such as migrants and refugees, with barriers that prevent them from accessing the health services they need (8, 9). Here, we use 'health equity' to mean the absence of unfair, avoidable, or remediable differences among population groups, consistent with WHO's framing of equity (10). Refugees and migrants may possess intricate and substantial healthcare requirements stemming from adverse environmental circumstances and insufficient access to health services (11)

Iran is also one of the leading countries accepting documented and undocumented migrants and refugees (12). In the Iranian context, we use "refugees" to refer to individuals formally registered as refugees (e.g., holders of Amayesh/Hoviat refugee cards or other official refugee documentation), and we use "migrants" as an umbrella term for foreign nationals residing in Iran. We further distinguish "documented" migrants/refugees from "undocumented" migrants, defined as individuals without a valid residence permit or refugee registration documentation, because legal status strongly shapes eligibility for insurance enrolment and continuity of care (13, 14). As with other host countries, Iran faces significant challenges in providing health services and access to healthcare for migrants and refugees (15). According to the United Nations High Commissioner for Refugees (UNHCR) statistics, as of June 30, 2024, 773,074 refugees legally resided in Iran, of which 761,000 were Afghan, and 12,000 were of other nationalities. Additionally, nearly 3 million people live under conditions similar to refugees, and 96% of the registered refugees in this country are Afghan nationals (16).

Identifying challenges and providing appropriate solutions to improve refugees' and migrants' access to healthcare services can help Iran achieve the WHO's universal health coverage goal by 2030 (17). In this debate article, we focus on four domains that are particularly salient for refugees' and migrants' health in Iran: primary health care, maternal care, HIV-related services, and rehabilitation for people with disabilities. These themes were selected because they align with WHO priority areas for refugee and migrant health (18), and because the Iran-specific peer-reviewed evidence is comparatively more robust in these domains than in several others. On this basis, the central question guiding this article is whether current policies and programmes in these four domains are adequate to ensure equitable access to health services for refugees and migrants in Iran, or whether more substantial reforms and targeted interventions are required to fulfil national and global commitments to universal health coverage.

Materials and Methods

Study design and approach

This debate article used an evidence-informed narrative synthesis with a policy-oriented lens to summarize Iran-focused evidence on access barriers and to discuss feasible policy options. We focused on four priority domains: primary health care, maternal care, HIV services, and rehabilitation based on their relevance to health-system responsiveness and the availability of Iran-specific evidence.

Evidence identification and selection

We conducted targeted searches in PubMed, Scopus, and Web of Science (last search: 11/2025) using combinations of terms related to Iran, refugees/migrants, and the four domains, e.g., Iran AND (refugee OR migrant OR Afghan) AND (primary health care OR maternal OR pregnancy OR HIV OR rehabilitation). Searches were limited to English and Persian publications and covered from January 2000 to November 2025. We

supplemented database searches with hand-searching of reference lists and targeted retrieval of key policy and technical documents (e.g., WHO/UNHCR and national materials). We included empirical and health-systems/policy studies that reported access barriers, service use, financial protection, or implementation constraints affecting refugees and migrants in Iran. We excluded studies not focused on Iran, papers without relevant empirical/policy information for the four domains, and non-access–related clinical studies without health-system implications. Titles/abstracts were screened, followed by full-text assessment for relevance to the debate question and domains.

Synthesis and development of policy options

We charted and summarized evidence thematically to identify recurring barriers within and across domains. To strengthen conceptual coherence, we organized reported barriers using Levesque's access-to-care dimensions (approachability, acceptability, availability/accommodation, affordability, and appropriateness), and mapped corresponding policy options to feasible health-system levers in Iran (financing/insurance, service delivery organization, workforce/cultural competency, information systems, and governance/partnerships) (19). For each included source, we extracted (where available) study setting/population (refugee/migrant and legal status), service domain, reported barriers/enablers, and any implementation or financing implications. Policy options were derived by linking the identified barriers to these health-system levers and prioritizing options with plausible feasibility in the Iranian context. As this is an evidence-informed narrative synthesis (debate article) rather than a systematic review, PRISMA reporting procedures were not applied. Given the purpose of informing policy debate rather than estimating intervention effects, no meta-analysis was undertaken. We did not conduct a formal risk-of-bias assessment; instead, we prioritized peer-reviewed Iran-focused evidence and triangulated findings across sources where possible.

Results

Primary Health Care (PHC)

Access barriers

The challenges of providing primary healthcare services to migrants and refugees in Iran can be divided into individual, organizational, and social levels (20). At the individual level, several communication barriers exist, including limited awareness of entitlements and available services, unfamiliarity with care providers, low health literacy, and cultural and linguistic differences. At the societal level, negative attitudes toward migrants and refugees, especially those of Afghan nationality, are among the main barriers. At the organizational level, there are weaknesses in insurance coverage, a treatment-oriented rather than preventive approach, insufficient clear and systematic information systems, and challenges in border health screening to assess individuals' health status and risk upon entry at the borders (12, 20).

One of the most important organizational barriers to providing primary healthcare services to immigrants and refugees is their health insurance coverage. Under a tripartite agreement among the Ministry of Interior, UNHCR, and the Health Insurance Organization, registered refugees and individuals with an Amayesh card (Iran's refugee registration card) can access basic health insurance (21). Until 2019, 100 percent of the insurance premiums for vulnerable refugees such as those with specific or incurable diseases or low-income individuals were paid by UNHCR. Apart from vulnerable groups, other refugees and Iranian citizens must also pay their own insurance premiums and those of their dependents. Undocumented migrants are required to cover most of their medical expenses themselves, particularly for services beyond basic primary care, which may lead to delays in seeking health services, often in the acute stages of disease and with comorbidities (20, 22). Additionally, considering that a significant proportion of migrants and refugees, especially those of Afghan nationality, are affected by infectious diseases such as tuberculosis, the prevalence of drug-resistant tuberculosis among them is higher compared to the general population. Border monitoring and primary healthcare for all new arrivals serve as essential components for tuberculosis management and for preventing the resurgence of diseases, including polio (23).

Policy options

Expanding affordable insurance coverage and introducing flexible premium payment mechanisms (e.g., monthly instalments) could improve financial protection for refugees and migrants. Strengthening border health screening and referral pathways, alongside culturally and linguistically appropriate communication support, may improve timely use of primary care and continuity of follow-up.

Pregnancy and Maternal Care

Access barriers

Approximately one-third of Afghan women residing in Iran are of childbearing age (24). Based on a study conducted on Afghan mothers from 2017 to

2019 in Iran, over 70% of Afghan women were in vulnerable conditions with low literacy levels and lack of access to social services. The childbirth rate among Afghan women rose from 3.4% to 5.2%, and Afghan births accounted for 4.2% of all births in Iran. During this period, the average maternal mortality rate for Afghan mothers was reported to be 43 per 100,000 people (25). This rate is much higher than the maternal mortality rate in Iran during the same period, which was 8.66 per 100,000 people (26). So, 8 to 10 percent of maternal deaths in Iran during this period were related to Afghan mothers (25). Afghan mothers are likely to experience at least one pregnancy complication, with those who are illiterate, undocumented migrants/refugees, or from lower socioeconomic backgrounds facing even higher risks of adverse outcomes (27). Therefore, reducing the adverse outcomes of pregnancy and ensuring access to adequate and affordable prenatal care among Afghan women is of utmost importance (28). In recent years, Iran has expanded free or subsidised antenatal care for registered Afghan women within the national primary health care network; however, important gaps in coverage, quality and affordability persist, particularly for undocumented women and those living in remote areas.

To access appropriate prenatal care for Afghan mothers, there are many challenges, such as negative attitudes towards prenatal care, misconceptions about service quality, poor quality of care, and inadequate socio-economic conditions (24). Cultural elements, including patriarchal norms and insufficient female autonomy, restrict women's freedom of choice and access to prenatal care. Furthermore, language barriers in communication with healthcare providers, limited access to prenatal care in remote areas, high transportation costs, lack of awareness of available insurance coverage for legal refugees, and the absence of affordable health insurance that covers prenatal services, especially diagnostic tests and screenings, constitute additional significant challenges. According to a report by the Iranian Ministry of Health, the prevalence of perinatal complications among Afghan women and their children is higher compared to the Iranian population (28).

Policy options

Ensuring the availability of quality antenatal care and addressing cultural, logistical, and insurance barriers could improve maternal and neonatal outcomes among Afghan women in Iran. Strengthening culturally responsive counselling and improving service navigation (including communication support for non-native speakers) may further reduce avoidable delays in prenatal care.

HIV Prevention and Treatment Services

Access Barriers

Despite providing free services to documented and undocumented migrants, there are still challenges in delivering HIV-related services that can be categorized into cultural, psychosocial, and service delivery aspects. Given that most Afghan migrants belong to the Hazara ethnic group and share religious and linguistic similarities with Iranian culture, these similarities may facilitate access; however, the distinct Afghan accent sometimes hinders effective communication and the receipt of necessary services. Additionally, the prevalence of patriarchal norms among Afghans residing in Iran creates limitations in providing services to this group. For instance, women often hide medical problems after losing their husbands, and men resist taking HIV tests, sometimes preventing women from accessing medical services (29).

Stigma and discrimination are significant psychosocial challenges, often manifesting as social exclusion and isolation from family, friends, and healthcare providers. The combination of prejudice with additional factors, including migration, gender, and addiction, results in increased health and service disparities (29, 30). For Afghan refugees and migrants, these challenges are further compounded by insecure legal status and cross-border mobility, which can interrupt continuity of care and make it harder to remain engaged in HIV prevention and treatment programmes. This situation is attributed to ineffective policies and educational programs for healthcare providers, as well as the lack of anti-discrimination laws, which increase discrimination in access to HIV services. Moreover, healthcare service access is limited due to the lack of coverage and integration of services. Medical tests, specialist consultations, and hospital care have become increasingly unaffordable. Since migrants are generally part of marginalized groups in society, they face various barriers, including time constraints and long distances to service centers, in accessing HIV services. Additionally, unstable legal residency status makes it difficult to maintain continuity of healthcare for Afghan migrants. Some migrants who do not have residency permits are reluctant to access HIV prevention and treatment services due to fear of arrest (29). Therefore, it is essential to provide solutions to address multiple barriers, including cultural stigma and legal challenges, to improve Afghan refugees' access to HIV services and improve their health outcomes for these vulnerable groups.

Policy options

Strengthening culturally sensitive counselling and provider training, alongside measures to reduce stigma and discrimination, could improve uptake of HIV testing and continuity of prevention and treatment services. Enhancing confidentiality

safeguards and leveraging NGO/community partnerships may help reduce fear-related delays in care among undocumented migrants.

Rehabilitation Services

Access barriers

Despite the improvement of the new refugee registration system in Iran for more precise status monitoring, comprehensive and accurate information on the prevalence and incidence of disabilities and the demographic characteristics of this group is still unavailable (31). The high rate of consanguineous marriages among Afghan migrants and refugees, poor nutrition of Afghan women during pregnancy, accidents during migration, and the working conditions of Afghan migrants have led to a high burden of musculoskeletal disorders and disabilities among them.

These factors have led to an increasing need for rehabilitation services in Iran. However, these services are accompanied by challenges, such as long waiting lists for rehabilitation services at government and charity centers, which cause many people to discontinue seeking these services (32). In addition, a lack of awareness of the Iranian health system, limited awareness of available support services, inadequate insurance coverage, and the greater concentration of rehabilitation and other specialized services in the private sector result in high out-of-pocket payments. As a result, even when services are available, refugees and migrants may face unaffordable user fees in private settings, which can delay initiation of rehabilitation and disrupt continuity of care (32, 33). These high costs, combined with inflation, affect individuals' financial capacity, and as a result, Afghan refugees and migrants encounter significant challenges in accessing rehabilitation services (32, 34). Moreover, limited engagement among rehabilitation service providers, limited service availability in remote areas, fear of arrest and deportation, lack of trust in modern treatments, and strict immigration laws are other significant barriers to accessing these services. Also, the disruption in the rehabilitation process of immigrants is mainly due to low health literacy and a lack of awareness of the roles and responsibilities of rehabilitation professionals (32).

Policy options

Expanding coverage for essential rehabilitation services, including through strategic purchasing/contracting with accredited private providers, and developing subsidised referral pathways could reduce out-of-pocket payments for refugees and migrants with disabilities. Improving rehabilitation literacy and strengthening communication support (including interpreter capacity where needed) may increase engagement and continuity of rehabilitation. In parallel, incentives for private-sector participation (e.g., negotiated tariffs, performance-linked reimbursement, and/or tax-related relief tied to provision of subsidised service packages for refugees/migrants) could help expand the availability and affordability of specialised rehabilitation care (33).

Discussion

In line with humanitarian efforts, Iran, despite not being a party to the 1951 Convention, has met many of its obligations beyond international expectations and has prioritized refugee health. These actions reflect a policy orientation that recognizes the significant health needs of Afghan refugees and migrants. The main contribution of this debate is to consolidate Iran-specific evidence across four priority domains and translate recurring access barriers into a feasible, implementation-oriented package of policy options explicitly considering financing, governance, and stakeholder constraints. Iran has taken practical steps to improve the quality of life for millions of documented and undocumented Afghan refugees (35). Such measures include providing free primary healthcare and extending insurance coverage to legal refugees, which has improved access to essential services (36). Notably, Iran launched a national health insurance scheme for registered refugees (often discussed in the literature as Universal Public Health Insurance/UPHI) in 2015; however, available analyses suggest that population coverage and uptake have remained limited, partly due to affordability constraints (e.g., household-based premiums), administrative requirements, and residual out-of-pocket payments, especially for services outside basic coverage (37). Also, some vulnerable undocumented migrants suffering from rare and incurable diseases are covered by insurance and receive financial support on a case-by-case basis through the Ministry of Interior.

From an implementation perspective, scaling up the policy options proposed in this article requires acknowledging political, administrative, and financial constraints. Politically, sensitivities surrounding undocumented migration and potential discontinuities in cross-sectoral agreements can affect policy stability. Administratively, fragmented stewardship across the Ministry of Health, the Iran Health Insurance Organization, and migration authorities, alongside eligibility verification and incomplete information systems, can create bottlenecks in enrolment and service navigation. Financially, constrained fiscal space, inflation, and refugees' limited ability to pay premiums may restrict benefit expansion and sustainability. Consistent with recent SWOT- and systems-thinking analyses, Iran's

strengths include a relatively strong primary health care platform and prior insurance integration efforts; key weaknesses include fragmented information systems and incomplete financial protection; opportunities include leveraging NGOs and community actors; and threats include economic pressures and negative public attitudes—factors that should guide prioritization and sequencing of reforms (12, 38). A brief stakeholder lens suggests that implementation will require alignment across the Ministry of Health, the Iran Health Insurance Organization, and migration authorities, while UNHCR and NGOs/community organizations can support outreach, enrolment facilitation, and service navigation especially for hard-to-reach groups; private providers and relevant professional bodies are also key actors particularly for specialised rehabilitation and can be engaged through contracting and incentive-aligned purchasing arrangements (16, 39, 40).

However, while these actions demonstrate commitment, they remain insufficient for achieving the Sustainable Development Goals. A policy debate arises here: although current measures are valuable, the scale of migration and the complexity of health needs require broader and more sustainable support systems (36). Strengthening financial protection is a key policy priority. One policy option is to divide insurance premiums into monthly payments to improve affordability. The possibility of increasing insurance coverage for migrants would be enhanced by reducing premiums and aligning them with the levels paid by Iranian citizens. In addition, a portion of the taxes paid by migrants could be allocated to insurance schemes and the provision of health services. Given that UNHCR does not support undocumented migrants, improving governance capacity and utilizing the capacity of other international and regional organizations could help finance and increase the effectiveness of health services for this group (22). Another debated issue concerns the role of health literacy and cultural attitudes. Although Iran has made efforts to provide insurance and primary care, the effectiveness of these measures depends on migrants' awareness and willingness to engage with the system. Improving health literacy through targeted education and offering economic and social incentives to households that enroll in insurance programs could increase participation (12). This approach aligns with international experiences. Across different countries, health literacy interventions have significantly improved healthcare utilization among immigrants (41). This rise in health awareness enables migrants to use primary care services at appropriate times and helps prevent health issues in their communities (42). International experiences provide further insight into how policy can evolve. For example, health information transmission in the United States to refugee groups using their native languages via social media has improved access to primary care (43). To address the linguistic and cultural challenges in providing primary health care services to immigrants in Germany, digital translation tools and native-speaking staff have been utilized (44). In Canada, training workshops for immigrants and involving community volunteers have strengthened trust and familiarized migrants with the health system. These strategies highlight a central policy debate: should host countries focus on adjusting their systems to migrants' needs, or require migrants to adapt? Evidence suggests that culturally responsive approaches lead to better health outcomes and higher satisfaction levels (39). For Iran, offering culturally informed training for health workers and improving cooperation between primary care centers and other public and non-governmental bodies could help promote more equitable access to health services (12).

Regarding maternal care, ensuring equitable access to high-quality, culturally respectful prenatal services is essential. Lessons from the United States demonstrate that community engagement and cross-sector partnerships can address language barriers and facilitate access for immigrant women (40). In this context, the use of multilingual staff and health service providers who are responsive to the needs of immigrant women has been suggested (45). Norway's experience also shows that interpreter services, psychosocial support, and basic intercultural training can help healthcare providers work with migrants (46). For Iran, these findings show that empowering Afghan women through social networks, education, and international support should be a main policy direction (24). In addition, addressing fears about deportation is essential to help undocumented Afghan mothers feel safe seeking prenatal and postpartum care (16, 27).

In the area of HIV prevention and treatment, difficulties in early detection continue to restrict timely access to services for refugees and migrants. Evidence from other countries shows that community-based approaches can improve these outcomes. In Uganda, for example, HIV self-testing and peer-support models have increased testing uptake and reduced stigma among refugee communities (47). Experiences from the United States further highlight the need for specialized training so that HIV service providers can respond effectively to the diverse needs of refugees and immigrants (48). Based on these international experiences, improving the quality of provider training, making better use of NGO capacities, supporting family and community partnerships,

securing assistance from international organizations, and increasing awareness among migrants and refugees can help expand access to HIV prevention and treatment services in Iran (29).

In relation to rehabilitation services, Iran has taken steps to support legal refugees, including providing insurance coverage and implementing Community-Based Rehabilitation (CBR) programs (36). However, the debate continues over how to ensure equitable access for all refugees and migrants. Strengthening insurance mechanisms, utilizing charitable and governmental capacities, and designing targeted financing systems could help expand access to rehabilitation services. In addition, educational campaigns to enhance rehabilitation literacy, respectful provider–patient interactions, and the use of interpreters for non-Persian speakers may further reduce existing barriers. Social support networks from both Iranian and migrant communities also play an important role in facilitating access (32). International experiences also show that improving the cultural and linguistic adaptation of rehabilitation services can increase their effectiveness for migrant populations. For example, culturally adapted rehabilitation initiatives in Norway have improved access to and acceptance of these services among migrants (49).

Strengths and limitations

This article concentrates on four domains that are particularly salient for refugees' and migrants' health in Iran, because these are the areas for which relatively robust, Iran-specific data and peer-reviewed evidence are currently available. This empirical grounding is a major strength, as it allows for a more balanced debate and concrete policy recommendations rather than purely speculative claims. However, this focus also reflects a structural limitation of the existing evidence base rather than a judgment about the importance of other health needs. For key domains such as non-communicable diseases, mental health, and occupational health, we found insufficient systematic and comparable data to support an equally rigorous discussion. Investing in stronger data systems in these areas is therefore an urgent priority for future research and policy.

Conclusion

A comprehensive, multidimensional strategy is essential for ensuring equitable access to health services for refugees and migrants in Iran. While this study highlights the critical importance of improving health literacy, strengthening health worker training, and enhancing community engagement, its principal contribution lies in demonstrating how these elements intersect with the distinct needs of Afghan pregnant women and HIV-positive individuals, and how migration policies shape their access to care. Building on these insights, future efforts should prioritize the development of robust data systems, the institutionalization of border-health screening, and the implementation of culturally informed service delivery models that can more effectively address structural disparities. To translate these priorities into action across decision-making levels, national authorities can focus on (i) expanding affordable insurance coverage with flexible premium payment mechanisms and clearer entitlement pathways for documented and undocumented groups, and (ii) strengthening governance arrangements for cross-sectoral coordination and financing. At the provincial level, implementing standardized referral pathways across PHC, maternal services, HIV programmes, and rehabilitation alongside provider training and interpreter/cultural mediation support can improve continuity and quality. At the local level, partnering with NGOs and community actors to deliver targeted health literacy outreach, service navigation, and follow-up support can reduce delays in care seeking and loss to follow-up, including for hard-to-reach and undocumented populations. By outlining actionable strategies such as shared insurance premiums (including instalment options), the use of trained native interpreters, stronger collaboration between NGOs and health providers, and the use of strategic purchasing/contracting where specialised services are concentrated in the private sector, this study establishes a clear and policy-relevant foundation for advancing universal health coverage and reinforcing migrant-responsive health policies in Iran.

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Data Availability

Not applicable. This article is based on published literature and publicly available data, all of which are cited in the footnotes.

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