Health and Socio-cultural Needs of Iranian Asylum Seeker Women Living in Sydney, Australia

By

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Certificate of original authorship

I, Sara Shishehgar, declare that this thesis, is submitted in fulfilment of the requirements for the award of PhD, in the Faculty of Health at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise reference or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

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Statement of contributions to jointly authored works contained in the thesis

This thesis contains two published literature reviews, which are presented in Chapter 2. My responsibilities, as the first author of the articles, included conducting the literature search, assessing the quality of the articles, extracting required data, synthesising the findings, and drafting the manuscripts. Dr Leila Gholizadeh, A/Professor Michelle DiGiacomo, and Professor Patricia Mary Davidson, the members of the supervisory team, provided guidance, commented on the manuscripts, and contributed to the discussion of the findings. I accept full responsibility for the accuracy of the findings presented in these publications and this thesis. I also presented the findings of this study in several national and international conferences, and media interviews as outlined below.

Peer-reviewed journal publications

1. **Shishehgar, S**., Gholizadeh, L., DiGiacomo, M. & Davidson, P.M. 2015. The impact of migration on the health status of Iranians: An integrative literature review. *BMC International Health and Human Rights*, *15*(1), p. 20.
2. **Shishehgar, S**., Gholizadeh, L., DiGiacomo, M., Green, A. & Davidson, P.M. 2017. Health and socio-cultural experiences of refugee women: An integrative review, *Journal of Immigrant and Minority Health*, *19*(4), pp. 259-973.

Conference presentations

3. **Shishehgar S**., Gholizadeh, L., DiGiacomo, M. & Davidson, P.M. Coping strategies applied by Iranian asylum seeker women in Sydney, Australia, International Council of Women Health Issues, Johns Hopkins University, Baltimore, USA, 6-9 November 2016

2. **Shishehgar S**., Gholizadeh, L., DiGiacomo, M. & Davidson, P.M. Living with insecurity: A phenomenological study on asylum seeker women, researchers for asylum seekers (RAS), interdisciplinary postgraduate conference, University of Melbourne, Australia, 17 November 2016
3. **Shishehgar S**., Gholizadeh, L., DiGiacomo, M. & Davidson, P.M. A review of health and socio-cultural experiences of displaced women, Annual International Conference on Fostering Human Resilience, Las Vegas, USA, 15 June 2015
4. **Shishehgar S**., Gholizadeh, L., DiGiacomo, M. & Davidson, P.M. Health and socio-cultural experiences of refugee women: An integrative literature review. The International Migration Conference in Monash University, Melbourne, 11-15 February 2015

Radio interviews

1. Health needs of refugee and asylum seeker women living in Western countries, October 2016. http://www.2ser.com/component/k2/item/25061-health-needs-of-refugee-and-asylum-seeker-women
2. Iranian immigrants' health status and living condition worldwide, November 2015. http://www.2ser.com/component/k2/item/19322-think-health-sunday-29-november

Abstract

Background:

Australia is known as a world leader for resettlement of asylum seekers and refugees; however, the country has recently introduced a number of legislative initiatives to deter illegal immigration, such as mandatory detention and temporary protection visas. Those who are released into the community remain in an insecure residency status for an undetermined period, often without permission to study and work. These legislations have affected Iranian asylum seekers who have entered Australia by boat since 13 August 2012, of which about half are women. Despite dramatic increase in the number of female asylum seekers in the recent years, they have remained understudied in health research.

Aim and objectives:

This study aimed to explore health and socio-cultural needs of Iranian asylum seeker women living in Sydney, Australia and strategies that they develop to build resilience in the face of migration-related circumstances/stressors.

Methods:

A narrative methodology was undertaken to explore experiences of 17 Iranian asylum seeker women who arrived in Australia by boat and were living in the community for two to three years awaiting a decision upon their refugee applications. The research methodology was informed by epistemology of constructivism and interpretivism. The resource-based model was used as the framework for designing the research including developing interview questions, data analysis, and discussion of the findings. The model provides an insight into the experiences of loss/gain of resources over forced migration and the impact of

these losses/gains on the adaptation and wellbeing of refugees during pre-migration, transit, and post-migration phases. The participants shared their experiences of migration via in-depth semi-structured individual interviews. A thematic analysis was undertaken to construct meanings and knowledge out of the narratives.

Findings:

Three main themes emerged from the experiences of the participants. These themes included: 1) embarking on the perilous journey, 2) arrived, yet living in-between, and 3) building resilience. Embarking on the perilous journey described experiences of the participants prior to migration and in transit, which included their reasons for leaving home and losses incurred during transit. From these experiences the following subthemes emerged: disempowerment of women, sacrifice for family, loss of safety/security, and loss of control over circumstances. Arrived, yet living in-between described their post-migration experiences, including time in detention and living in the community. Participants shared their mixed feelings of living in a prison; yet, a safe place during detention. Their experiences of living in the community included insecure residency, cultural incongruity, and utilising healthcare services. Participants developed a number of coping strategies to help them build resilience towards the migration difficulties.

Conclusion:

Asylum seeker women are more likely to experience traumatic experiences pre-migration and during transit. Their post-migration experiences are impacted by resources they have lost pre-migration and during transit as well as adverse immigration policies, in particular insecure residency and unemployment, limiting asylum seekers' capacity to invest on resources to prevent further loss, recover

from lost resources and gain new resources. These traumatic experiences increase the risk of health issues, in particular mental health problems amongst this population, and their need for appropriate healthcare and supportive social services. Although these findings reflect the experiences of Iranian asylum seeker women, the results can be useful for similar populations. The women strived to build resilience and gain the control of their lives through adoption of emotion focused and problem solving coping strategies.

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List of abbreviations

ABS	Australian Bureau of Statistics
CASP	Critical Appraisal Skills Program
CINAHL	Cumulative Index of Nursing and Allied Health Literature
IMA	Irregular Maritime Arrivals
NSW	New South Wales
PBS	Pharmaceutical Benefits Scheme
PPV	Permanent Protection Visa
PRISMA	Preferred Reporting Items for Systematic Review
PsycINFO	Psychology Information
PTSD	Post-Traumatic Stress Disorder
RBM	Resource-Based Model
STARTTS	Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
TPV	Temporary Protection Visa
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
USA	United States of America

Glossary of terms

Acculturation: A dynamic process through which a person adjusts to a different culture during resettlement in a new environment. [1]

Adaptation: A process by which new immigrants adjust and integrate socially, politically, and economically within a new environment and the host society. [2]

Assimilation: Immigrants reject their own culture and become involved in the new culture. In brief, assimilation allows for attachment to the host culture including language, values, traditions, behaviours, and interests while refusing one's own culture. [3,4]

Asylum seeker: An individual whose international protection claim for refugee status has not yet been determined. As part of the obligation to protect refugees, the country of asylum is normally responsible for determining whether an asylum seeker is a refugee or not. [5,6]

Brain drain: Migration of talented, skilled, and trained individuals that results in a reduction of skill resources of the origin country. [4]

Country of origin: Also source country, sending country, or home country – refers to the country that migrants come from. [7]

Culture: The symbolic organisation that a social group chooses or values. A combination of language, customs, ideas, beliefs, aesthetic technical knowledge, tastes, values, and lifestyles may also represent a culture. [8]

Deportation: The act of removing a non-national person from a state or country to their country of origin after refusal of their residency application or termination of permission to stay. [9]

Detention: In the migration context, detention refers to confinement of irregular migrants (who enter a country with no valid visa/ or overstay after termination of their visa) in oreder to restrict their movement. Irregular migrants are often subject to detention because their action violated immigration laws. [10]

Emigrant: (Also migrant) refers to persons who left their usual place of residence to settle elsewhere. Emigrant describes the move relative to the point of departure. [7]

Forced migration: A migratory movement when something threatens people's life and livelihood, whether arising from man-made or natural causes (e.g. movements of internally displaced persons, refugees, and people displaced by environmental, natural, chemical, nuclear disasters, famine, or development projects). [4]

Immigrant: A person who is displaced internally or internationally to settle in a country other than their country of origin. [7]

Immigration: A process of international movement by which a non-national person moves into a country for the purpose of settlement. [4]

Integration: Occurs when immigrants are engaged with the dominant culture of the new environment while keeping their own culture. [11]

Internally displaced person: Someone who has been forced to leave their place of habitual residence to avoid the effects of violation of human rights, armed conflict, human-made or natural disasters, but who has not crossed an international border. [4]

Irregular maritime arrivals: A person who enters Australia by sea without authority and became an unlawful non-citizen upon their entry.[12]

Irregular migration: Movement of people outside the regulatory norms of the origin, transit, and receiving countries. From the perspective of the origin country, it refers to when a person crosses an international boundary without fulfilment of the administrative requirements for leaving the country, such as obtaining a travel document or a valid passport. From the perspective of destination countries, it refers to entry, staying or working in a country while violating the country's immigration regulations. There is also a tendency to use the term 'illegal migration' in cases of trafficking or smuggling of migrants.[4]

Migrant: A term that covers a wide range of people who cross borders for a variety of reasons to settle in a foreign country, not to be confused with short-term visitors such as traders and tourists.[13]

Migration: A process by which a person changes their residence by crossing borders of a country. The process encompasses departure, transit, living in the destination, and return. This movement may result in permanent or temporary residence in a new country.[4]

Push-pull factors: Push factors are social, economic, or political factors that drive people out of their country of origin. Pull factors include positive aspects of the host country, such as job opportunities, safety, and better life and economic opportunities that attract people in.[4,14]

Receiving country, host country, third country, or country of destination: A country that has admitted a certain number of immigrants and refugees on a yearly basis by

decision of its leaders including ministers of immigration or parliament. In the case of repatriation or return, the country of origin is also called the receiving country.[4]

Recipient country: Also country of destination or host country – the country in which migrants are located after crossing international borders.[7]

Refugee: A person outside the country of their nationality who is unable or unwilling to return to the country of origin due to fear of being persecuted for reasons such as religion, race, nationality, political opinion, or membership of a particular social group. A refugee is a person whose refugee status has been recognised under the 1951 Convention.[6,15]

Resettlement: The relocation and integration of a person (internally displaced person, refugee, immigrant, etc.) into another geographical environment, usually in a third country. Refugees often lodge their refugee application in a transit country, then upon their application approval they will be transferred into another country that has agreed to admit them, called the third country.[4]

Smuggling: An action through which a person who is not a national or a permanent resident of a country or state is brought in illegally. Contrary to trafficking, smuggling is not usually associated with exploitation, violation, or coercion, but does have direct or indirect financial and material benefits for smugglers.[4]

Transit country: A country different to the country of origin through which migratory flows move. Migrants pass through transit countries (legally or illegally) to enter a host country.[16]

Chapter 1: Introduction

1.1 Introduction

Migration is commonly described as a stressful process of movement that has a significant impact on migrants' health and wellbeing.[17] In this study, the term 'immigrant' specifically refers to people who have already arrived in host societies, while 'migrant' refers to those who have embarked on the journey, but have not yet crossed the boundary of the host country.[7]

Migrants can be classified into two categories- forced and voluntary. The distinction between voluntary and forced migrants is still controversial;[18] however, voluntary migrant generally refers to someone who is capable and interested to choose to migrate [19]. Forced migrant refers to an individual outside the country of their nationality, who is unable or unwilling to return to the country of origin due to fear of being persecuted for reasons, such as religion, race, nationality, political opinion, or membership of a particular social group.[5,6] What differentiate asylum seekers from refugees is their application status. A refugee is a person whose refugee status has been recognised under the 1951 Convention.[6,15] However, an asylum seeker is an individual whose international protection claim for refugee status has not yet been determined. As part of the obligation to protect refugees, the country of asylum is normally responsible for determining whether an asylum seeker is a refugee or not.[5,6]

Forced migrants, who do not have a choice regarding leaving their country, often experience physical and psychological trauma in their countries of origin or during their journey to a destination country. The process of forced migration has been linked to the experience of traumatic events, intense emotional disturbance prior to migration followed

by losing key resources such as social networks, culture, identity, and community.[20] Losing these resources over different phases of migration – pre-migration, in transit, and post-migration – escalates the vulnerability of forced migrants.[20,21]

In the context of increasing global forced migration, the health issues of asylum seekers and refugees, particularly their mental health, have become a key human rights concern.[22] Earlier studies have shown improvement in refugees' mental health following resettlement in host countries,[23] which may not be the case for asylum seekers who lack secure residency status. The terms 'refugees' and 'asylum seekers' are often presented interchangeably in the literature, but there is a critical distinction between them. Compared to refugees, asylum seekers often experience more unfavourable conditions and live in a prolonged temporary residency status with an uncertain outcome of their refugee request. These adverse experiences can have short and long-term negative effects on their wellbeing and health status.[24]

Previous studies report on the resettlement experiences of refugees in Australia and their impacts on mental wellbeing.[25,26] However, current research on the experiences of asylum seeker women and their health needs is scarce. In an attempt to address this gap in the literature, there have been calls for health researchers to prioritise this population's health.[27-31]

The study undertaken for this dissertation aimed to fill the gap in the literature by shedding light on the experiences of Iranian asylum seeker women, as a vulnerable population group, with the objective of identifying their socio-cultural and healthcare needs. As detailed in Section 1.5.3, Iranian women comprised the highest number of female asylum seekers in Australia's immigration detention facilities in 2013 and

2014.[32,33] Accordingly, this study explored this population's experiences of migration, resettlement, and health outcomes.

1.1.1 Statement of problem

Internationally, moves towards nationalism and populism have changed attitudes and approaches to migration.[34,35] Australia is well-known as a host country for asylum seekers and refugees.[36] In spite of this reputation, the country has recently imposed some legislations against asylum seekers who arrive by boat, including compulsory detention, entitlement to a temporary protection visa (TPV), and long waiting on bridging visas.[37-41] These legislations have been in place to deter arrivals via boat. According to these legislations, people who to Australia by boat, without a valid Australian visa, are considered to as 'illegal immigrants' and detained in detention centres for uncertain periods while their refugee applications are processed.[38]

Due to disagreement between the Department of Home Affairs and the Australian Senate on re-introducing TPVs in 2013, as detailed in Section 1.3.2, a large number of asylum seekers were released into the community on bridging visas.[22] A bridging visa is a temporary visa that allows people stay in Australia lawfully while their visa application is reviewed.[42] Due to conditions attached to the bridging visas, particularly restrictions for work or study, asylum seekers may confront difficulties in settling in the new society.[43,44] In addition, the protracted process of protection visa applications results in many bridging visas being expired, causing additional distress, limitations, and deprivations for asylum seekers.[45]

Moreover, the portrayal of asylum seekers as 'illegal immigrants' and 'queue jumpers' in the media triggers racial and prejudicial attitudes towards asylum seekers.[46]

Immigration is widely considered a stressful process;[17] it can particularly challenging for asylum seekers who have often experienced life-threatening events before and during migration. Even after arriving in destination countries, they may face unexpected difficulties and trauma, such as worrying about their family members left behind in their country of origin, lack of secure residency status, experience of discrimination and racial behaviours, communication difficulties in the new socio-cultural society, and loss of socio-economic status.[21,47,48] The difficulties inherent in immigration augmented with previous trauma experience, and restrictive legislations of the host country can adversely affect the health and wellbeing of asylum seekers.[49]

As demonstrated in the literature, and detailed in Section 1.5.2, due to the political and economic condition of Iran, the number of Iranian asylum seekers who came to Australian by boat increased significantly between 2010 and 2013.[50] Iranian women were the highest asylum seekers residing in the Australia's immigration detention centres in 2013.[33] These women were released into the community on bridging visas while awaiting their refugee applications to be processed for several years. The resulting insecure residency status and the associated consequences may place Iranian asylum seeker women at high risk of mental health problems impact on their successful settlement. The social and health needs of this vulnerable population group have remained overlooked in the literature. This study was undertaken to explore the Iranian asylum seeker women's experiences of migration and settlement in Australia to help develop insight into their social, cultural, and health needs.

1.1.2 Research aim and objectives

The aim of this research was to explore the health and socio-cultural needs of Iranian asylum seeker women who live in Sydney, Australia. The objectives were to:

1. Explore Iranian asylum seeker women's experiences of migration over three phases of migration including pre, transit, and post-migration
2. Identify Iranian asylum seeker women's wellbeing and their experiences of using healthcare services in Australia
3. Investigate the development of and use of Iranian asylum seeker women's coping strategies and resilience.

1.1.3 Research questions

Four research questions were posed to guide this study:

1. In what way do Iranian asylum seeker women experience migration to Australia?
2. In what way do Iranian asylum seeker women perceive and give meaning to their living in Australia?
3. In what way does migration to Australia impact on Iranian asylum seeker women's health and wellbeing?
4. In what way do Iranian asylum seeker women increase their resilience towards migration-related difficulties?

1.1.4 Outline of the thesis

Chapter 1 introduces the purpose and significance of the study. It provides the background to the study, including the context of migration worldwide, immigration to Australia, Iranian culture and history of migration, and forced immigrants in Australia.

Chapter 2 comprises two reviews of the literature that are presented in the form of two peer-reviewed journal articles. The first review explores the health and socio-cultural

experiences of refugee women, and the second review presents Iranian immigrants' health status and resettlement experiences more generally.

Chapter 3 introduces the theoretical framework of the study, which is based on the resource-based model (RBM).

Chapter 4 describes the methodology of the study. It includes a description of the research design, including epistemology, the research perspective, and methodology of the study. Strategies undertaken to strengthen the rigour and trustworthiness of the research findings, and ethical considerations are also discussed in this chapter.

Chapter 5 reports on the key informants' demographic characteristics, and the findings about pre-migration and transit experiences.

Chapter 6 provides findings about the post-migration experiences of participants in Australian detention centres, and of those living in the community and utilising healthcare services.

Chapter 7 presents the strategies that participants employed to build resilience and cope with life challenges during transit and the early stages of resettlement in Australia.

Chapter 8 discusses the study findings, comparing them with previous research. The experiences of the study participants are also discussed through the lens of the RBM. Finally, the limitations and strengths of the study are discussed.

Chapter 9 concludes the thesis and provides implications for policy, healthcare practice, and future research.

1.2 Migration as a global phenomenon

International migration, whether voluntary or forced, is increasingly driven by social, political and economic factors.[51] Migration is defined as crossing borders to seek a better future, family reunion, investment, and international protection [51,52]

Nowadays, ongoing movement and mobility of people across boundaries has become the norm. The United Nations (UN) (2019) reported that international migrants reached 272 million in 2019, 51 million more than 2010.[53] According to the UN's report on international migrant stock in 2019, 84 million migrants lived in Europe and 81 million in Asia. North and Latin Americas, Africa, and Oceania were hosting 71 million, 27 million, and eight million international migrants, respectively. Almost half (48%) of the international migrants were women.[53] It is predicted that the number of immigrants will reach 405 million by 2050 if the current trend continues.[54]

Although the unprecedented number of migrants and displaced persons is predicated by geopolitical instability and factors such as climate change,[55] demographers and social researchers have not yet been able to fully explain people's reasons for migration. A number of migration theories have emerged to explain population movements within or beyond wider demographic boundaries. The earliest migration theorist, Ernest Ravenstein, developed the theory of laws of migration in 1889, which describes push and pull factors, as influencing a person's mobility.[56] According to this theory, unfavourable circumstances in the country of origin 'push' people out, and favourable conditions in the destination country 'pull' them in .[56] In 1966, Everett Lee revised Ravenstein's theory to highlight the role of push factors as internal factors that reinforce migration. He added that four main factors affect the migration process – including the conditions of the origin country, the conditions of the destination country, intervening obstacles, and personal

factors.[52] Each factor consists of several elements that encourage individuals to either remain in their country of origin or compel them to migrate. The role and influence of these factors are different for different individuals. For example, a favourable education system in the destination country might pull people with children at school age out of their country of origin, but it is not an incentive for others to migrate. In the case of refugees and asylum seekers, factors such as war, violation of human rights, political conflicts, and persecution in their country of origin push them to leave their country.[52,57] Moreover, in most cases of forced migration people have no time to investigate the destination country, or have limited or no choice in determining their destination country.[58]

In addition, encouragement from other people from the same culture and availability of resources, such as financial support, assistance with housing and employment, reunification with family members, and educational opportunities in destination countries, might pull individuals to migrate.[59,60] However, intervening obstacles, such as political and physical barriers, distance, and having children, can impede or even avert migration.[52] The same obstacles may, indeed, affect different people in different ways. Perceived trivial obstacles for some, such as transport costs, may be prohibitive to others. Personal factors can also affect individuals' responses to intervening obstacles. Lee (1966) describes factors such as gender, age, social class, education, personal values, family ties, and intelligence as personal factors influencing people's decisions to migrate and their perceptions of migration-related difficulties. While some of these factors are stable throughout a person's life cycle, others may be related to a particular stage.[52] For example, knowledge about a destination ascertained through study or personal contacts can impact individuals differently to migrate or not.

Berry proposes a theory of acculturation that has been used in immigrants' health studies.[3] The theory presents four substantial strategies in acculturation and resettlement. Integration is referred to as involvement in both new and own cultural communities through which individuals receive the most social support. In contrast, through marginalisation immigrants reject both the new culture and their own values and culture. This means the immigrants do not receive support from cultural communities. In theory, integration is the most successful strategy of acculturation, and marginalisation is the least successful. Assimilation and separation are in between acculturation and marginalisation. In assimilation, the person rejects their own culture and assimilates to the new culture, and in separation the individual rejects the new culture and remains in their own culture. In assimilation and separation, individuals receive social support from one cultural community. As a whole, integration was introduced as the most effective strategy for long-term wellbeing.[3] A recent study on Turkish immigrants residing in the Netherlands examined the relationship between the four acculturation strategies and psychological disorders.[61] Ince et al. (2014) categorised the participants in participation and non-participation groups. Those in the participation group combined integration and assimilation to participate in Dutch culture. The non-participation immigrants adopted separation and marginalisation strategies. Results of the study demonstrated that the immigrants in the participation group were at lower risk of developing psychological disorders, including depression and anxiety.[61]

Murphy (1973) argues that host societies play a critical role in the successful settlement of immigrants in two ways. First, in multicultural societies, immigrants are less likely to exclude themselves from the new society (marginalisation and separation) and renounce their own culture (assimilation), instead they are more likely to integrate into the host

society through preserving their own culture and accepting the host culture. Second, multicultural societies often provide support for immigrants through several strategies, such as providing culturally sensitive healthcare services and strengthened ethno-cultural communities. In these societies, immigrants are more likely to maintain their psychological wellbeing.[62]

As opposed to voluntary migration, where interested and capable individuals choose the opportunity to migrate, forced displacement involves people leaving their original countries in haste for self-protection without any preparation, with no time to say goodbyes, and with no hope of returning to their homeland.[19,63] A refugee or asylum seeker is a person who is unable or unwilling to return to their country of nationality because of fear of persecution due to religion, race, nationality, or membership of a specific social group.[64,65] As defined earlier in Section 1.1, refugees and asylum seekers are different in terms of their residency and immigration status in host countries; however, they are often presented interchangeably in the literature.[66,67]

The population of forced migrants has never been higher than it is now. In 2014, the global number of forced migrants was 59.9 million including 38.2 million internally displaced persons, 19.5 million refugees and 1.8 million asylum seekers.[68] In 2018, the number of forced migrants increased to 68.5 million. Of these, 40 million were internally displaced persons, 25.4 million were refugees, and 3.1 million were asylum seekers.[69] Drastic deterioration of security, armed conflict, and human rights concerns in a number of countries including the Syrian Arab Republic, Iraq, Afghanistan, Serbia, and Kosovo and Eritrea have been reported as the main reasons for the sharp increase in the number of forced migrants. In 2014, Germany, the United States of America (USA), Turkey,

Sweden, and Italy together received six out of every 10 new asylum seekers amongst 44 industrialised countries. Australia received 8,960 asylum applications in 2014.[70]

Forced migrants, either refugees or asylum seekers, often confront resettlement difficulties in host countries. While all immigrants experience common constraints over the early stages of residing in a new country, forced migrants are more likely be disempowered when dealing with resettlement challenges.[19] This may be related to traumatic experiences prior to migration and during their journey, which could undermine their coping and resilience abilities when facing further difficulties in destination countries.[19,71] The foremost concerns of forced migrants are social and cultural issues. Social issues often contain barriers on employment, housing, loss of social networks and relatives, loss of social support, concerns about residency status, stigma attached to forced migrants, lack of information about social services and healthcare services in host countries, and eventually a sense of isolation and separation from the host society due to their appearance, accent, skin colour, lifestyle, and beliefs.[72-76] Due to a lack of time to obtain knowledge about the destination country, forced migrants often lack cultural intelligence and communication skills, which inflicts a sense of shock upon arrival in the host country. The culture shock is often associated with conflicts within family members, including couples and children, and imposes a great deal of stress on the affected individuals.[73,77]

1.3 Immigration to Australia

Australia has been known as a "classical country of immigration" [78] since 1788 when the first immigrants from European countries anchored in Sydney Harbour.[79] World War II then established a milestone in the development of Australia's immigration history. Shortly after the war, Australia set up a large-scale immigration program – a nation-

building program – which involved many people from Europe and Asia who immigrated to Australia. It was believed that a larger population could guarantee the safety and industrial prosperity of the country.[80,81]

British immigrants were the largest group of immigrants in Australia for many years; however, the pattern of immigration changed during the decades after World War II. Eastern European immigrants, mostly from Germany and Italy, immigrated to Australia to form the principal non-British immigrants during the 1950s. In the 1960s, Greek immigrants became the largest non-British group in Australia. In the same period, Asian immigration began and grew further in the late 1970s. While South-East Asian immigrants constituted one-fifth of all Asian immigrants throughout the 1970s, immigrants from India started to increase to one-quarter of all Asian immigrants in later years. This growth coincided with a significant intake of Turks, Lebanese, and Indo-Chinese from 1975 to 1977.[82]

The size, composition, and distribution of the Australian population have been affected by the patterns of migration. While only 9% of the Australian population were overseas-born and 2% were from non-English speaking nationalities in 1947, the comparative figures for 1981 were as high as 20% and 12%, respectively.[82] Since then, almost 6.8 million immigrants have been settled in Australia, comprising 28.22% of the total Australian population in 2015.[83] This growth continued, reaching 62% of the total population in 2017, before remaining static for the year ended 31 March 2018.[84,85]

The figure 1.1 generated from the Parliament of Australia website demonstrates trends in Australian population over the last four decades including the net overseas migration.[86]

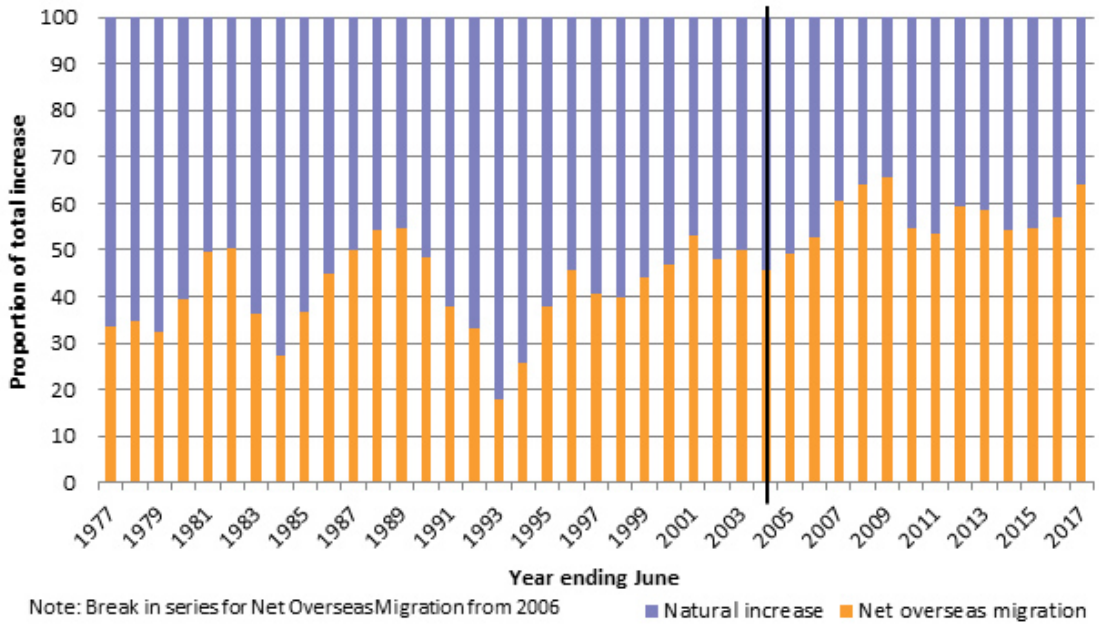

Figure 1.1: Components of change, 1976–77 to 2016–17

1.3.1 The Australian Humanitarian Program

In addition to Australia's reputation for its capacity to receive immigrants from different countries, it is well-known as a world leader for resettlement of refugees and asylum seekers via the Australian Humanitarian Program.[36,87] Australia settled over 700,000 refugees and asylum seekers between 1945 (after World War II) and 2011.[88] In 2012-2013, the Australian Humanitarian Program allocated 20,000 places for refugees, with 12,000 and 8,000 places for offshore and onshore protection respectively.[89] Further, 13,750 places were allocated to the humanitarian program in 2013-2014 comprising a minimum of 11,000 places for offshore protection and up to 1,000 places for women at risk, particularly from Africa, Asia, and the Middle East.[90]

The Australian Humanitarian Program comprises two main functions:

1. Onshore protection/asylum: expresses Australia's commitment to people who have arrived in Australia and are found to be eligible as refugees in need of protection.[91]

2. Offshore resettlement:
    - Refugee: expresses Australia's commitment to refugee protection by offering resettlement in Australia to individuals who are typically outside their origin countries, and are subject to persecution, substantial discrimination, and violation of their human rights in their countries. The majority of these individuals are referred by the UNHCR to Australia for resettlement.[91]
    - The Special Humanitarian Program: for UNHCR identified refugees who are sponsored by a proposer who is an Australian citizen, permanent resident or eligible New Zealand citizen, or by an organisation that is based in Australia.[91]

The Australian Humanitarian Program aims to:

1. Provide permanent resettlement to those most in need, who are in desperate situations overseas, including in refugee camps and protracted humanitarian situations
2. Reunite refugees and people who are in refugee-like situations overseas with their family in Australia
3. Use resettlement strategically to help stabilise refugee populations, reduce the prospect of irregular movement from source countries and countries of first asylum (transit countries) and support broader international protection.[90]

The program resulted in granting a total of 11,762 visas under the offshore component and 2003 visas under the onshore component in 2015-2016 in Australia.[87]

1.3.2 Asylum seekers in Australia

In 1951, Australia signed the United Nations Refugee Convention and was recognised as a pioneer refugee resettlement country. In spite of its reputation of welcoming refugees

and asylum seekers, it is the first country amongst its confederate Western countries that has imposed a compulsory detention term on all people who entered Australia without a valid visa since 1992.[37-39] According to this legislation, all 'unlawful non-citizens', that is, people who are not Australian citizens and do not have a valid visa, are referred to as 'unauthorised arrivals' or 'illegal immigrants' and are detained in detention facilities, including onshore and offshore detention centres, for uncertain periods while their refugee applications are processed.[38]

Compulsory detention, as a significant deterrent on irregular maritime arrivals (IMA), has been accepted by both major political parties – the Liberal-National Coalition and the Australian Labor Party. The parties assert that seeking asylum by boat does not automatically result in freedom nor recognition as a refugee to be settled in Australia, but rather, results in spending an indeterminate period in detention.[38,92] Despite compulsory detention, the number of boat arrivals remained significantly high, at the rate of 25,218 people in mid-2013.[93] According to the report of the Department of Home Affairs (2013), the number of people who resided in onshore and offshore detention reached 8,189 in December 2013.[94] Despite a reduction in the population due to speeding the process of release of asylum seekers into the community, the number of detained persons still remained high at 4,687 persons in December 2014.[32] In 2015, there were still 3,251 asylum seekers in immigration detention facilities.[95]

In addition to compulsory detention, community detention was introduced in 2010 to allow vulnerable asylum seekers to live under residence determination in the community while their refugee request was being processed.[96] These people are referred to as community-based asylum seekers, and they are also subjected to supervision arrangements, such as travel limitations or curfews, by the Department of Home Affairs,

and can be returned into detention at any time. These people have no access to Medicare or rights to study and work.[96] Medicare is a funded health insurance scheme that provides free or subsidised healthcare services to Australian citizens and permanent residents. It provides free hospital services for public patients in public hospitals, subsidises private patients for private hospital services, and subsidises medical services such as consultations with general practitioners or specialists.[97] Instead, community-based asylum seekers' healthcare issues are managed by the International Health and Medical Services, which maintains a network of health providers including general practitioners, specialists, pharmacists, dentists, psychologists, diagnostics, and allied health services (e.g. optometrists).[98] The Department of Home Affairs reports that 603 people were living in the community after being approved for residence determination in 2015.[95]

Apart from the mandatory detention policy and the community detention program, entitlement to a temporary protection visa (TPV) is another issue that asylum seekers encounter in Australia.[41] This bill was passed into legislation by the Howard Government on 20 October 1999. While many recipient countries provide TPVs to deal with the mass influx of asylum seekers, Australia routinely applies this to all boat arrivals whose refugee requests are accepted.[23] TPVs are granted to boat arrivals who are found to be genuine refugees and in need of protection, in place of a permanent protection visa (PPV). In other words, asylum seekers would be granted refugee status under the same criteria, but instead, only temporary protection is given. This means that the refugee status of this population is to be reassessed every few years. Holding a TPV not only does not facilitate permanent resettlement in Australia, but also prevents these individuals from reuniting with their families left behind in their countries of origin. This program has not been used in the same way in other recipient countries.[99]

Although regulation of the TPV was cancelled in 2008, it was re-introduced on 18 October 2013 following the increasing number of boat arrivals.[12,22] This affected those who arrived by boat to Australia before 19 July 2013. However, the Australian Senate overruled the re-introduction of TPVs on 3 December 2013. Consequently, 27,000 asylum seekers remained on bridging visas with no certainty about their future residency status.[22] A bridging visa is a temporary visa that is granted by the Department of Home Affairs to allow people stay in Australia lawfully while their main visa application is reviewed.[42] Asylum seekers are often granted a type E bridging visa which includes 'no study' and 'no work' conditions; however, the conditions could vary as according to each individual's circumstances. Further conditions attached to this visa are no right to family reunion, and no right to re-enter Australia if they travel overseas.[43,44] Both community-based asylum seekers and asylum seekers holding a bridging visa are supported by caseworkers from a variety of service providers, such as Australian Management and Education Services, Australian Red Cross, and Asylum Seeker Resource Centre.[100] Contrary to community-based asylum seekers, asylum seekers holding a bridging visa are eligible for Medicare. Due to lengthy delays in processing protection visa applications, 33,000 asylum seekers were left with expired bridging visas.[45] This situation limited the affected people's access to healthcare services, work, and financial support from the government. Furthermore, they remained at serious risk of being deported to their country of origin at any time.[101]

In addition to the direct impact of the legislation of indeterminate compulsory detention and living with insecure residency on asylum seekers' health and wellbeing, the government's anti-asylum seeker policies can trigger prejudicial attitudes including hatred, discrimination, and hostility against this population in the society.[102,103] Asylum

seekers have been portrayed in the media as taking advantage of the humanitarian program for their own economic gain. Terms such as 'illegal' and 'queue jumpers' used by the media have also amplified this perception that asylum seekers threaten Australia's social security and identity.[46] In a study that investigated Australian residents' attitudes towards boat arrivals, participants believed that deterring asylum seekers from entering Australia could improve national security, health, the economy, employment, crime rates, and the lifestyle of Australians.[102] There is a belief that as contemporary Australia has not experienced prolonged wars or oppression on its own land, it cannot comprehend and sympathise with people who have been forced to flee from their homeland.[40] Regardless of the reason for this attitude, being discriminated against, ignored, and isolated by ordinary people in Australia delays asylum seekers' integration and affects their health-seeking behaviours and mental wellbeing.[104]

Although forced migrants are more likely to report socio-economic challenges, such as social isolation, cultural and religious diversity, language barriers, and negative attitudes of the general Australian population,[105,106] the literature reveals some positive outcomes associated with migration. A sense of security, better work and education opportunities for women, living in a well-organised society, support from government, good facilities such as public transport and education, freedom, and better lifestyle were some of the positive experiences shared by Afghan and Kurdish refugees settled in Western Australia.[107] However, studies conducted since the introduction of the restrictive policies against asylum seekers suggest that the policies result in more negative experiences, such as poor living conditions and delayed integration into Australian society.[108,109]

1.4 The impact of migration on forced immigrants' health

Migration, even under ideal circumstances, is a transition that is likely to create a sense of suspicion, confusion, instability, and insecurity regarding cultural identity, perceived social support, and social and financial status; this may have adverse effects on wellbeing of immigrants.[110,111] What emerges from literature is that all types of migrants are at risk of the adverse effects of migration-related difficulties.[112,113] However, some studies assert that being an asylum seeker is associated with a higher risk of experiencing resettlement challenges and mental health problems.[111,114] Settling in a new culture and society may be perceived as a greater challenge by an asylum seeker who has experienced torture and life-threatening events before and during migration. Common experiences of asylum seekers prior to migration include violence, torture, war, death of family members, and political conflicts. Many also face traumatic experiences after escaping from danger and violence during their journey to the destination country, such as physical torture, detention, or loss of family members.[115] Prolonged stress over the course of migration has been linked to mental health problems.[49] Even after arriving in destination countries, they may face unexpected hardships and trauma, such as worrying about their family members living back in their previous home country, communication problems, difficulties in adjusting to the host society's culture, loss of socio-economic status, and experience of prejudice and discrimination.[21,47,48] The experience of detention, isolation and marginalisation in host societies, where asylum seekers expect to reach safety and be settled, may result in depression, anxiety, a sense of powerlessness, and lack of self-advocacy.[115]

A growing body of research acknowledges that lack of health literacy and language and cultural barriers to using healthcare services in host countries that are shared with other

immigrants, adversely affect forced migrants' health and wellbeing.[116,117] Stress attached to the forced migration process and health-threatening circumstances that individuals often face during the journey and after arriving in the host country, along with the cross-cultural barriers in the use of healthcare services, places refugees and asylum seekers at greater risk of health disorders.

As international forced migration has become a norm in recent years, immigrants' experiences, human rights, and health issues have gained attention from human rights advocates and social and health researchers.[118,119] Experiencing detention, in particular in countries with a policy of mandatory detention such as Australia, raises issues around the physical and psychological health of asylum seekers during detention and following release into the community.[120] In addition, instability and a prolonged fear of deportation may intensify the adverse effects of migration.[121] Daily fear and angst due to uncertain residency status and the likelihood of deportation can take a toll on asylum seekers' emotional and mental wellbeing.[122] Heeran et al. (2014) conducted a comparative study in which they compared asylum seekers with refugees in Switzerland in terms of their psychological wellbeing.[123] Results of the study revealed that asylum seekers were at significant higher risk of post-traumatic stress disorder (PTSD), anxiety, and depression compared to refugees. The higher rate of psychological disorders was not only related to pre-migration traumatic experiences, but also associated with the insecure residency of the asylum seekers.[123]

Overall, due to past torture, injuries, and health-threatening events, as well as post-migration difficulties contributing to lower integration and higher risk of physical and mental health problems, asylum seekers may have an increased need for healthcare services; however, due to their uncertainty of residency status they may face inequity in

accessing these services in host countries.[124] Perception of discrimination when utilising healthcare services is a further factors that delays care seeking resulting in a higher rate of long-lasting psychological problems in forced immigrants.[124,125]

1.5 Iranian culture and history

The term 'culture' refers to a set of symbolic organisations that distinguish a special group of people. The symbols include language, beliefs, ideas, customs, aesthetic technical knowledge, tastes, and lifestyles that peole in a social group value.[8] The notion of culture as the way people live and what they believe determines the process of migration through which people leave their own set of historical and social circumstances and move to another. Clearly, it is impossible to transport a whole culture, but cultural studies demonstrate migrants carry some aspects of their culture and integrate them into the new one.[126] Some familiarity with Iranian culture and history can assist in a better understanding of lived experiences, post-migration expectations, and settlement of Iranian immigrants. Iran is in the Middle East, a region that has been a centre of attention throughout history for several reasons, including its rich natural resources (in particular oil and gas) and strategic location with access to international waters through the Persian Gulf and the Indian Ocean. Iran was known as the Persian Empire over 2,500 years ago. The country was the symbol of life and civilisation due to its land, population, affluence, human skills, prosperity, and education.[127] Iranians are known as a vastly heterogeneous population with diverse subcultures and minority subpopulations including Azari, Gilaki, Mazandarani, Kurd, Arab, Lur, Balooch, and Turkmen.[127]

Farsi/Persian is the official language of Iran, spoken primarily by 51% of the population; however, there are several local languages such as Azeri, Gilaki, Kurdish, Arabic, Luri, Balooch, and Turkmen.[128] Islam is the official state religion in Iran, with about 98% of

followers (including 89% Shi'a and 9% Sunna). Christian, Baha'i, Jewish, and Zoroastrian comprise the remaining 2%.[129] Despite the diversity of cultures and spoken languages, there are significant commonalities amongst Iranians.[114] Iranian society is a traditional society that is strongly family-oriented, with parents and children having defined responsibilities within the family context. For example, parents are responsible for supporting their children and providing them with economic assistance before, and sometimes after, marriage.[130] Children usually live with their parents until they get married. Therefore, they experience a delay in dealing with social stressors associated with independent living.[131] Iranians are known for having high aspirations for their children's educational and occupational success. Family, as a whole, is a source of support in which parents make the critical and sensitive decisions for all family members.[132]

Moreover, in Iranian culture, men are recognised as breadwinners for their families while women generally assume responsibility for housework and childcare. Culturally, men are expected to work outside the home and make vital decisions for their families, with women expected to dedicate their life to their husband, children, and home. While women have been increasingly taking part in activities outside the home, they are still expected to assume full responsibility for the household.[133] While there are some perspectives that relate these gender-based roles and responsibilities to the Islamic tradition in Iran, there is another idea that links the patriarchal culture to the Persian culture.[134,135]

As a whole, Iranian identity is centred on Iranian cultural rituals.[136] A sense of ethnic or cultural pride is obvious amongst Iranians, who believe that Iranian culture is something to be proud of. Nevertheless, after migration Iranians tend to acculturate and adopt some aspects of the host society's culture. A study by Daha (2011) on Iranian immigrants in

the USA revealed a strong tendency of Iranians to integrate into the host country's culture, such as choosing American names and identity,[137] although they still carried their cultural baggage and preserved their traditions, beliefs, and values.[138,139]

1.5.1 History of Iranian migration

In the literature, there are some landmarks in the history of Iranian migration. The first landmark backs to 1979 shortly after the Islamic revolution, when many high ranking officials, investors, and scholars immigrated to countries such as the USA, Australia, Canada, and European countries.[140,141] Another landmark is related to the civil war in three provinces of Iran including Kurdistan, West Azerbaijan, and Torkeman Sahra in 1979.[142] This coincided with the eight-year war between Iran and Iraq, which resulted in the demolition of hundreds of cities and villages, compelling hundreds of thousands of Iranians to flee their homes to safer cities inside the country and beyond its boundaries to Western countries.[142] Over the past couple of decades, another wave of migration took place. Skilled migration, family reunification, and humanitarian programs comprised a relatively new immigrant group amongst Middle Easterners.[143,144] Highly skilled Iranians have migrated to developed countries to further their chances of success, which is depicted as 'brain drain' in the literature.[145] Economic refugees have also migrated; this has continued from the mid-1990s to the present day as a result of social and economic unrest following international sanctions against Iran.[145]

Currently, over six million Iranian-born immigrants live in North America, Europe, Persian Gulf States, and Australia.[146] As political unrest and economic instability continue in the Middle East and Iran, the influx of Iranian immigrants to other countries is expected to continue.[147]

1.5.2 Iranian immigrants in Australia

Over the last two decades, the events that pushed and pulled Iranians to migrate, as mentioned in Section 1.5.1, has resulted in a sharp increase in the number of Iranians residing in Western countries, including Australia. Reportedly, 22,546 Iranian-born people were living in Australia in 2006.[148] This number reached 58,106 in 2016, an increase of 158% over 10 years.[149] The current population includes 31,609 men and 26,497 women. The biggest concentration of Iranians in Australia is found in metropolitan Sydney and Melbourne. According to the latest reports from the Australian Bureau of Statistics (ABS) (2016), which updates every five years, 21,740 Iranians live in metropolitan Sydney, including 11,793 men and 9,947 women.[149] The ABS (2008) previously reported that forced migrants from Iran comprise an increasing proportion of settlers in Australia under the humanitarian program.[150] This has contributed to the significant growth in Iranian population in Australia over the recent years.

The ABS (2016) reported that 31% of Iranian-born immigrants in Australia were Muslim, followed by 30% who did not state any religion. 11% stated their religion as Baha'i and 5% were Christian. 75% of these immigrants had very good English language skills, and 43.6% had a university degree – significantly higher than the Australian general population where 22% hold a post-school qualification.[149] Despite high educational attainment, Iranian immigrants experience high levels of unemployment compared to the Australian general population (17.6% vs. 9.6%). However, those who are employed are more likely to work in professional positions compared with the Australian general population (35.8% vs. 22%).[149] These statistics may further support Adibi's (2008) claim that despite all obstacles, Iranian immigrants in Australia "do not consider themselves as an oppressed minority, but rather as a group trying to improve their status further".[142]

1.5.3 Iranian asylum seekers in Australia

Like other immigrant groups in Australia, the Iranian community consists of people who have arrived in different ways, including skilled migrant program, family reunification, investment, and humanitarian programs. As evidenced in the literature, due to the current political and economic condition of Iran, number of Iranians who sought asylum after arriving by boat increased significantly between 2010 and 2013.[50] According to the report of the Department of Home Affairs (2013), 1,754 Iranians were held in detention facilities in 2013, comprising about 29% of all IMAs in the same year (see Appendix 1).[33] The number of women was reported as 430, presenting the highest female asylum seeker group followed by 127 women from Sri Lanka as the second highest female asylum seeker population in Australia in 2013.[33] This trend continued in 2014 when Iranians comprised 30% of all IMAs in Australia. In 2014, a total of 828 Iranian asylum seekers were detained, including 173 women (see Appendix 2).[32] Some asylum seekers were released into the community and some decided to return voluntarily to Iran, reducing the number of detained Iranian asylum seekers to 129 persons in December 2016, including 113 men, 15 women, and less than five children (see Appendix 3).[151] Those who were released into the community as community-based asylum seekers comprised 88 men, 78 women, and 89 children (see Appendix 4).[151] Despite living in the community, they had to comply with a set of conditions determined by the Ministry of Immigration.[152] For example, they had to reside at the address specified by the Ministry of Immigration in their residence determination letter.[152]

In addition, the number of bridging visas granted to asylum seekers in general increased from 22,708 in 2013 to 28,739 in 2016.[33,151] No new statistics are available as due to the recent immigration policies arrival by boat has stopped.

1.6 Significance of the study

Australia, as a multicultural country and one that signed the United Nations Refugee Convention (1951), has an obligation to recognise various minority groups' socio-cultural and healthcare needs to develop a society in which all racial groups feel settled, prosperous, and in a good health.[153,154] However, in a wave of global trends towards nationalism, re-introduction of strict immigration policies against asylum seekers, including indeterminate detention[38] and TPVs[12,22] is a risk to the health and wellbeing of this population, and delays their resettlement and integration into their host society, in this study, Australian society.

As detailed in Section 1.5.1, heightened political and economic unrest in Iran has motivated more Iranians to leave their country by any means. For example, the isolation of Iran from international markets has resulted in a constrained economy and a high rate of unemployment at 25%–30%, that pushed many Iranians to migrate using the asylum route.[145,155] A large proportion of those who immigrated to Australia sought asylum through the maritime way, and therefore were detained and ultimately resettled in the community with bridging visas, as detailed in Section 1.5.3.[151] While there are numerous studies surrounding the impact of immigration policies, such as compulsory detention and TPVs on asylum seekers' health and wellbeing,[23,38,108,156] little is known about asylum seekers' living experiences in the community while they are on a bridging visa or an expired bridging visa awaiting a response regarding their refugee request.[22,45] This population could be affected by limited access to healthcare services and social rights, such as lack of permission to study and work.[101] Recent studies draw a link between exacerbation of asylum seekers' psychological issues and difficulties they confront in

host countries, such as detention, and prolonged insecure residency status that bring further restrictions in employment, study, and access to social services.[157,158]

Moreover, immigrant women seem to be at a higher risk of mental health issues compared to men due to their generally lower socio-economic status that can result in their exclusion from the new environment.[159,160] Despite this risk, the literature mainly amalgamates men and women when presenting asylum seekers' experiences of resettlement and their health and social needs.[73] Iranian women, are affected by previously living in a patriarchal culture where their basic rights, such as their choice for divorce, are violated and they become predominantly dependent on men financially and for making decisions.[161,162] This dependency may result in Iranian women having inadequate resources mentally and socially to be able to cope with the ongoing challenges of immigration as they experience further delays in integration into a new environment. This study aimed to investigate the migration experiences of Iranian asylum seeker women and their health status during the early years of resettlement in Australia.

The next chapter reports on the integrative review of the literature to explore asylum seeker and refugee women's health status and experiences of living in hosting countries, including Australia. A subsequent review depicts Iranian immigrants' living situations and wellbeing in Western countries, including Australia.

Chapter 2: Integrative literature review

2.1 Introduction

Chapter 1 presented this study's aim, objectives, research questions, and contextual information about the phenomenon of forced migration worldwide and Australia as a host country for the resettlement of refugees and asylum seekers. The first chapter also described Iranian's cultural background and history of migration through the humanitarian program and forced migration. The impact of forced migration on the health status of refugees and asylum seekers was also presented, and the significance of this study was justified.

This chapter presents two integrative literature reviews that were undertaken to provide insight about the experiences of refugee and asylum seeker women and Iranian immigrants of living in host countries and their health status. The reviews were important in summarising the literature pertinent to the experiences of immigrants and refugees. They helped the researcher identify gaps in the literature and informed the design of the study including development of the research questions and the study's interview guide.

Section 2.2 presents an article in its preprint form: Shishehgar S., Gholizadeh, L., DiGiacomo, M., Green, A. & Davidson, P. M. 2017. Health and socio-cultural experiences of refugee women: An integrative review. *Journal of Immigrant and Minority Health, 19*(4), pp. 959-973. The article reviewed refugee and asylum seeker women's experiences in host countries and the impact of these experiences on their health status. *The Journal of Immigrant and Minority Health* was chosen due to its relevance and peer review process. In addition, as an international forum, the journal contributes to diverse fields including public health, epidemiology, sociology, immigration law, ethics, and

population research, providing the researcher the opportunity to disseminate their work to a wide audience. The international scientific indexing impact factor of the journal in 2017 was 1.284, and for the last six years was 1.658. This article is presented in its published format in Appendix 5.

2.2 Health and socio-cultural experiences of refugee and asylum seeker women: An integrative review

2.2.1 Background

In recent decades, the number of forced migrants has risen dramatically worldwide because of war, political conflict, and oppression.[70] Globally, about half of the refugee population consists of women;[163] yet, they often remain underrepresented in research and receive inadequate attention and support as a result of socio-cultural disadvantages and language barriers.[164] Over the last decade, a developing body of literature on forced migrant women and their health needs has predominantly revolved around their reproductive and antenatal health.[165,166] There remains limited evidence on the lived experiences of migration, living in a culturally diverse society, and health outcomes for this prominent population. Research considering those aspects have often addressed the experiences of refugees and asylum seekers without gender differentiation or have not separated forced migrants from the general immigrant population.

Evidence suggests that refugees and asylum seekers, and in particular women, are vulnerable to mental health issues[167-169] such as PTSD, depression, and anxiety related to adverse life experiences, including lack of social support, poverty, poor health conditions, and discrimination.[170,171] As wives and/or mothers, women bear extra burdens in the process of migration in order to support family members to adjust to a new way of living,

and often undertake the role of protecting and upholding family values, culture, and beliefs in the new environment.[172]

Resettlement is particularly challenging for women due to their lower socio-economic status.[173] For example, compared to men, language barriers more often impede women's access to education, employment opportunities, and healthcare services; factors that help facilitate adjustment and adaptation to the new society.[174,175] O'Mahony and Donnelly (2013) call for further research to explore the experiences of refugee and asylum seeker women in pre-migration and post-migration stages in order to help identify their unique health concerns and social support needs.[176] The authors of this review set out to analyse the relevant literature from the past decade to help understand refugee and asylum seeker women's resettlement and socio-cultural experiences, and the impact of these experiences on their health and overall wellbeing.

2.2.2 Methods

An integrative literature review was undertaken through a systematic approach to address refugee and asylum seeker women's health status and experiences of resettlement in host countries.

2.2.2.1 Eligibility criteria

Peer-reviewed and grey literature published between 2005 and 2014 were included to reflect the contemporary contextual conditions for refugees and asylum seekers in host countries. Studies needed to focus on adult women who left their country seeking asylum or who were settled as refugees in other countries. Quantitative, qualitative, and mixed method studies were included to help capture the various aspects of refugee and asylum

seeker women's experiences. Articles were excluded if they focused on children or male refugees, or addressed immigrants' issues in general.

2.2.2.2 Search strategy

A systematic search strategy was developed in consultation with a health librarian. Databases and search engines used were Medline, CINAHL, ProQuest, Academic Search Complete, Scopus, Informit, PsycINFO, Google Scholar, and Google. Search terms and keywords were 'refugee*', 'asylum seeker*', 'humanitarian', 'women', 'female', 'cultur*', 'social', and 'health'. Reference lists of the included articles were also searched for possible relevant articles. Article titles and abstracts were reviewed by the first author (SS), who applied the inclusion and exclusion criteria. If unclear, the full texts of the articles were also reviewed. To establish consistency in the application of inclusion/exclusion criteria, two other researchers (LG and MD) independently assessed the 20 included articles against eligibility criteria. Any inconsistency was discussed until consensus was reached.

This integrative review followed the Preferred Reporting Items for Systematic Review (PRISMA) guideline to ensure a systematic search (Figure 2.1). The PRISMA guideline is an established appraisal tool enabling researchers to perform practical and transparent literature searches and report on systematic reviews.[177]

2.2.2.3 Quality assessment and data analysis

Quality of the relevant articles was assessed using the Critical Appraisal Skills Program (CASP) tool. Quality of the included articles was assessed as high to medium as presented in the summary of included articles in Table 2.1 (at the end of this article). Using a specifically designed data extraction table, the articles were reviewed for their aim, sampling, research instrument, main findings, type of study, and quality. Extracted data

were discussed by all authors (SS, LG, MD, AG, and PMD) to increase the rigour of the review, and dissensions were resolved through conversations amongst the authors.

The post-migration phase of the RBM, which is a combination of Berry, Hobfoll, and Lazarus and Folkman's theories, provided the structure for analysis and presentation of the findings.[20] The RBM focuses specifically on migrants' adaptation process and their psychological wellbeing. It reflects the various resources immigrants use to meet their needs, goals, and demands in the new societies. The assumption is that when needs, goals, and demands are met appropriately by accessible resources, individuals are satisfied with their psychological health and their integration in the new society is facilitated.[20]

The findings of the included qualitative papers were read several times by the first author (SS) to derive direct analysis without a model or priori expectation. The primary findings were discussed by authors (SS, LG, MD, and PMD) to assure the trustworthiness of derived categories and findings. The categories were then grouped under the main categories of the RBM to provide an overview of refugee and asylum seeker women's experiences and health issues. The RBM is explained in Chapter 3 in this thesis.

2.2.3 Results

The initial literature search yielded 909 articles. Following removal of duplicates, 638 articles remained for further review. A total of 608 articles were subsequently excluded because they did not focus on refugee and asylum seeker women, their resettlement experiences, their health status, and amalgamation of immigrants and refugees' experiences, and men and women in the reporting of results. The search process and article selection are depicted in Figure 2.1. Of the included 30 articles (see Table 2.1), the

majority were qualitative (n = 22), followed by quantitative (n = 5), mixed methods (n = 2), and literature review (n = 1).

Overall, four main categories were identified. These included: cultural factors, social and material factors, personal factors, and resilience factors. The findings of this review are explained in greater detail in the following sections.

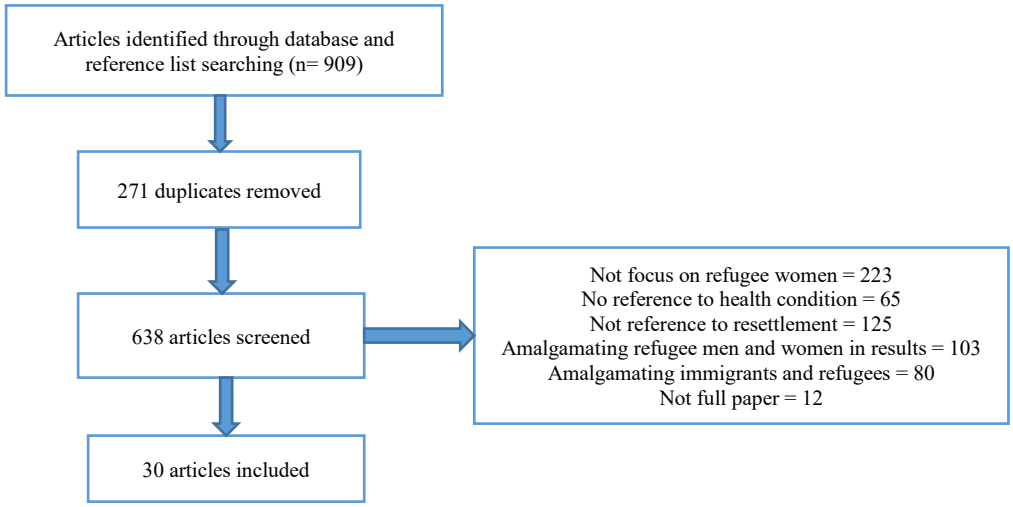

Figure 0.1: PRISMA flow chart of search process

2.2.3.1 Cultural factors

The results of the analysis of the findings of included studies suggest that language barriers and cultural shock were two common factors affecting integration of refugee and asylum seeker women into the new society and their health status. Lack of proficiency in the dominant language of the host country reduces the women's chances of interaction with others and sharing their experiences and burdens. Low levels of competency in the host country's language has been associated with increased feelings of loneliness, depression, and reduced self-esteem.[178-181]

Moreover, language deficiency affects refugee women's access and utilisation of healthcare services. Floyd and Sakellariou (2017) examined eight refugee women's

experiences of access to healthcare services in Canada. The women described that language barrier resulted in their dependence to others, isolation, sense of fear and shame, and rejection by healthcare providers.[182] They perceived themselves as "stupid" who were not able to secure a job or engage in social activities.[182] Refugee women, consequently, can become socially isolated, a factor that negatively affects their resettlement process.[166, 167] In their qualitative study, Casimiro et al. (2007) explore the impact of language proficiency on the process and length of resettlement amongst refugee and asylum seeker women from Iraq, Sudan, and Afghanistan residing in Australia. The study found that those women who learnt English before immigration felt more comfortable with the settling process, including securing a job, accessing education services, and promoting personal autonomy.[183] The researchers argue that although interpreter services are frequently available in countries including Australia and Canada, their uptake and utilisation varies across population groups. Refugee and asylum seeker women may not be willing to share their personal experiences with interpreters due to a fear of misinterpretation, exposure, long waiting times, and perceived impatience of interpreters.[183]

Culture shock is a multidimensional stressful experience resulting from experiencing an unfamiliar lifestyle or as a result of contact with a different culture in a new environment.[184,185] This is commonly experienced by refugee and asylum seeker women and described as 'dropping from the moon to the earth'.[186] This expresses the immense shock these women experienced facing a new culture in a new society. In a study by McBrien (2011), refugee mothers from Vietnam, Iran, and Somali were concerned about their ability to survive in the USA because of a lack of cultural intelligence. They were also concerned about the extent of changes in their children's behaviour and undermining their own

cultural values. Iranian refugee women were particularly apprehensive about their daughters developing disrespectful habits, being involved in sexual relationships with boys, and accessing illegal drugs in schools.[77] They related these issues to the cultural distinction between Iran and the USA, where children are exposed to learning about sexual activities at school age and lacking respect for teachers.[77] Interestingly, this study did not reveal any complaints from the women who had sons. This might be related to the patriarchal culture that the Iranian women had grown up with.

In Australia, Sudanese refugee women expressed concern about losing their parenting authority, and described their children's adaptation to the Australian norms and culture as "losing their children". Not being able to use the traditional means, such as physical punishment made the refugee women worried about their role as mothers within the family.[187] To reduce the stress of parenting in the developed country, Australia, the women applied new ways of parenting, such as negotiation and talking more to their children.[187]

Access to sexual health information was another experience that was in discrepancy with the refugee women's traditional culture. Svensson et al. (2017) conducted a qualitative study on refugee women from Afghanistan, Iran, and Somali living in Sweden. The women compared their previous knowledge about sexual health pre-migration and after arrival in the new country. They stated that sexual health services was more accessible compared to their home countries where seeking and asking for sexual health information was a cultural taboo and shame. The new insight acquired in Sweden opened their eyes and changed some women's everyday life by changing their attitude to communicate with their husband and other men.[188]

2.2.3.2 Social and material factors

Employment issues, financial hardship, housing issues, and lack of social support were the main social and material factors experienced by refugee and asylum seeker women that directly or indirectly affected their health and wellbeing and adaptation to the new society. Lack of a secure job has been widely reported as a critical factor affecting the mental health and wellbeing of refugees.[77,178,183,186,189-191] Employed refugee women are more likely to extend their social networks and report better health status.[178,179] The strong link between employment and language competency revealed an interrelationship between social and cultural factors. In a study on refugee women, some participants expressed a feeling of sadness and shame with their job in the USA. In particular, women who had higher education remarked on the sense of loss of dignity that underemployment brought to themselves and their families.[192]

Financial hardship was another issue that refugee women struggled with during resettlement in the host country. African and Afghan refugee women residing in Australia expressed stress from being unable to afford their daily living expenses. In particular, women with children were more anxious about financial struggles due to their children's school expenses.[180]

In addition, refugee and asylum seeker women face many challenges in securing safe and affordable housing. Difficulty in obtaining housing is a post-migration stressor that hinders resettlement of refugees. Difficulties include the perception of realtors that refugee renters may not be able to pay their rent or that multiple children may damage properties.[179,181,193-196] Not having convenient and secure accommodation is a stressful resettlement experience that should not be neglected by healthcare providers who aim to improve the health and wellbeing of refugee and asylum seeker women.[196]

Loss of material resources and inability to regain them in refugee settings have been reported in the literature. Usta and Masterson (2015) interviewed 452 Syrian refugee women residing in a refugee camp in Lebanon. The women rated their health as poor and very poor and related it to their lack of access to material resources. They complained of the lack of adequate food and water, toys for their children, and a suitable accommodation to live. They reported suffering from various health conditions, such as anaemia, cardiovascular issues, mental health issues, and gynaecologic infections, and believed that their poor health was resulted from their deprivation from the basic conditions.[197]

Refugee and asylum seeker women also report loss of social support from family, friends, and relatives. In particular those women whose husbands left them to seek profit from more advantaged women in the host country were more likely to experience sadness, hopelessness, and poverty.[198] Feeling overwhelmed and disempowered was another negative experience perceived by refugee women.[180,181] Congolese refugee women in the USA complained of the burden of parenting and raising children in the host country, where there were little support, and described the loss of family and friends' support in their home country as a significant resource loss The employed women described that leaving their children with strangers during working hours was a stressful experience.[181]

The availability of formal support by the host country governments was another theme that emerged from the literature. The results of a qualitative study on Syrian refugee women in Canada suggested that most women appreciated the support they received from the government including financial support, housing, and medical care. They believed that these supports eased their adjustment, and protected them from mental health problems. However, the women stated that the stigma around mental health disorders prevented them from seeking help when they required.[199] A study on refugee women in

Ireland revealed poor language, lack of childcare support, transport difficulties, and high level of stress as the main barriers in access to healthcare services by pregnant refugee women. On the other hand, provision of resources, such as reliable accommodation and food, presence of an accompanying person, access to interpreter, and provision of transport mitigated their anxiety and increased their utilisation of healthcare services.[200] In line with the studies above, Goodman et al. (2017) reported that the formal supports, such as initial resettlement funds, free English classes, and immediate assistance from caseworkers, were effective supports which helped refugee women's settlement and integration in the USA.

2.2.3.3 Personal factors

Family separation is another problem that refugees and asylum seekers often confront as a result of leaving their homeland. Many refugee and asylum seeker women describe leaving behind family members in an unsettled situation as a 'traumatic experience'.[179,181,186,190,192,197,201-203] Uncertainty about the condition of family members who have been left behind is a significant source of stress amongst refugee and asylum seeker women.[197,204] An intense feeling of regret and loss was reported by refugee women who left their children behind in their country of origin.[192] Separation from family members is seen as a major contributing factor to the experience of depression and other mental health disorders.[201-203,205,206] In contrast, having a united family enhances and maintains relationships and family wellbeing.[204]

Experience of sexual violence emerged as the negative experience that refugee and asylum seeker women faced either through their journey or during resettlement in the host country.[181,192,197,207] Refugee women from El Salvador and Congo residing in the USA revealed sexual harassment by either armed groups in the refugee camps or their intimate

partners and family members and also pregnancy that was resulted from rape.[181,192] In addition, a Syrian asylum seeker woman in Germany reported sexual violence from her husband. The woman added that she did not receive any real support from neither police nor her social worker.[207]

Exploitation of young girls is another significant concern for refugee and asylum seeker women. Women in some refugee camps report worrying about their daughters being involved in sex work. In a study of a refugee camp in Africa, mothers explained that although they could not afford it, their young daughters requested luxuries, such as clothes and shoes, to be accepted in the new society and 'look smart', a need that may lead them to be involved in sex work. Alternatively, some women want to support their young daughters by undertaking extra work or being engaged in sex work themselves.[189]

Apart from the negative experiences, refugee women expressed their sense of safety and security in the host countries. Congolese refugee women in the USA appreciated the level of safety that they perceived while living in the community although they had a strong preference to not be alone at home. The inconsistency might be due to their pre-migration experience of torture and trauma.[181]

Some women may also lose their hope for a bright future. A study in the Congo found that refugee women wished to improve circumstances only for their children and had no hope of a better future for themselves.[189] These adverse feelings can result in social isolation making some refugee women vulnerable to decision-making biases and the loss of successful social integration.[198] In contrast to the experiences of refugee women from Africa, Bosnian refugee women were optimistic and believed in a bright future for their children and themselves in the new society.[208] Collectively, these adverse experiences

hamper refugee and asylum seeker women's adjustment to the new societies and increase risk of mental health problems.[202]

2.2.3.4 Resilience factors

The review of the literature suggests that refugee and asylum seeker women employ various strategies to cope with their new way of life. Sentiment of gratefulness, spiritual fulfilment, seeking social support, sharing experiences, and avoiding traumatic memories are commonly used resilience strategies that help these women maintain equilibrium in spite of their uncertain status and ongoing resettlement distress.[180,186]

Remembering hardships in their country of origin, made refugee women to be grateful and increased their satisfaction of living in Australia. Vromans et al. (2018) interviewed refugee women from five low income countries during the early years of resettlement in Australia. The women recalled the memories of hardship and expressed their concern and sympathy with those who were left behind. They expressed their satisfaction of life in Australia and gratefulness to the Australian government.[180] In contrast, some women chose not to think about their traumatic memories and believed that this helped eased their resettlement and protected them from mental health disorders.[180,192]

Spirituality is defined as a non-religious strategy that can contribute to coping with new situations and accompanying shocking experiences,[186] such as loss of parental authority,[187,201] loss of professional status,[183] and family disconnection.[186] It is also described as belief in a higher power that leads to a sense of meaning, purpose in life, and wellbeing.[178] In addition, 'standing on our legs' is positive thinking about dealing with migration-related difficulties that leads to a sense of pride, empowerment, hope, and wellbeing.[178]

Family and ethnic communities are additional supporting resources contributing to the wellbeing of refugee and asylum seeker women and their integration into a new society. Ethnic communities support the women by linking them to community and healthcare services, which can ease their resettlement during the early years of living in host countries.[178,192] These communities provide an opportunity for women to share their experiences and cultural values with their counterparts, alleviating the burden of distress.[180,192,209] Communities also provide support in the form of information and empower refugee and asylum seeker women to deal more effectively with their existing concerns.[178] The social supports provided by ethnic communities are recognised as a critical predictor of refugees' mental wellbeing.[202,208,209]

In addition, re-establishing kinship and ensuring family unity helps to mitigate adverse effects of forced migration.[204] As such, refugee and asylum seeker women who lack family resources may experience more vulnerability to mental health problems.[203] Apart from immediate family members, extended family and close friends are important sources of support.[203]

Making self-sacrifices for family has been reported as a strategy that helps refugee and asylum seeker women to feel empowered and confident with their position in the family and their identity.[186]

2.2.4 Discussion

This integrative review highlights individual and socio-cultural difficulties that refugee and asylum seeker women may encounter in the process of resettlement and the impact of these experiences on their health and wellbeing. The results of this review suggest that

the circumstances surrounding resettlement may adversely affect individuals' health, while adopting effective strategies helps mitigate these impacts.

In spite of refugee and asylum seeker women's tendency to be integrated into new societies, an inability to communicate in the language of the host country may affect their successful integration.[178,179,183] This finding was supported by a study on Vietnamese refugee women residing in the USA, which reports that integration is easier for those who arrive at a younger age due to their higher ability to acquire English language than adults and the elderly.[210] However, some other studies explained that experiences of family breakdown and discriminatory behaviours in host countries are more likely to hinder integration of refugee and asylum seeker women.[183,211] This inconsistency may be related to differences in study designs, and needs further research.

Language deficiency may also negatively affect refugee and asylum seeker women's health by hindering them from accessing healthcare services including preventive screening programs, such as mammography and cervical screening tests;[211] however, some believe that lack of information and 'shyness' are more influential barriers to the uptake of these services.[212] There is a need for further research to identify barriers to utilising healthcare service in specific populations including refugees and asylum seekers.[213,214]

Supporting refugee and asylum seeker women to obtain affordable and good quality accommodation is another critical factor that can facilitate their successful resettlement and accelerate the integration process.[215,216] Lack of a secure job[215] and stigma towards refugees and asylum seekers[195] have been identified as the major obstacles to attaining safe and convenient housing. However, this seems to vary from place to place, even within the same host country.[215] In Canada, for example, refugees with a secure job in

Montreal, are able to afford a convenient property, while the story is different in Vancouver and Toronto due to the high cost of accommodation, shortage of social housing, and racial discrimination. These findings, however, cannot be generalised due to the small sample size and existent bias related to recruitment from a specific immigrant organisation.[215]

Separation from family members and the fear of never seeing them again exposes refugees and asylum seekers to the risk of depression.[192] While self-esteem, sense of mastery, and integration of forced migrants usually improve over time in host countries,[217-219] the risk of depression seems to increase with the length of time away from close relatives.[202] However, having a united family as a significant supporting resource, as described in the RBM, facilitates forced migrants' integration and better mental health .[20] On the other hand, discrepancy between refugees' and Westerners' concepts of family makes it difficult for refugees to apply for family reunification. Refugees who are mostly from Eastern cultures, define family as people who are living together including extended family; not just parents, spouses, and children. Therefore, loss of a great resource of support adds to this culturally specific population's burden of stress and leads to the development of mental health disorders.[180,220] Understanding different cultural meanings of 'family' and making changes towards reunification policies should be important considerations for policymakers when developing evidence-based and tailored supportive programs to help these people improve their health and wellbeing.

Providing information about healthcare services in host countries can enable refugee and asylum seeker women to appropriately identify and seek professional help in a timely manner.[221,222] Moreover, culturally and linguistically appropriate mental health discussion groups provide a platform for refugee and asylum seeker women to share their

experiences and burdens and attain social support from individuals who share common experiences and challenges.[223]

Resilience facilitators were also identified as important factors affecting the resettlement process and health of refugees and asylum seekers. These factors also need to be understood to provide a more comprehensive picture of immigrants' strengths and challenges (Figure 2.2).

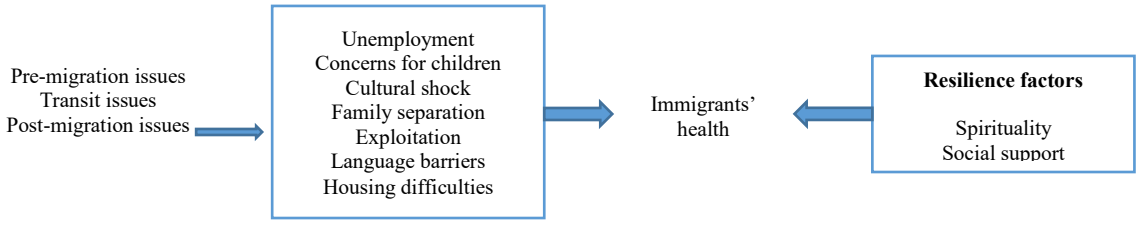

Figure 0.2: A developed conceptual framework based on the review findings

Resilience, which is an overlooked area in many migration-related frameworks, such as the RBM, is increasingly gaining attention.[219,224-226] Resilience is a dynamic and multidimensional factor[227] that empowers refugee and asylum seeker women to cope and adapt to a new situation, and thus recover from traumatic and stressful conditions.[228] While the loss of resources is a threat to the mental health of migrants, in particular forced migrants,[229,230] applying strategies to build resilience can compensate for the loss and improve health and wellbeing.[231]

There are many studies that emphasise the significant role of resilience factors, such as feeling grateful, spirituality and social support, in enhancing individuals' health and wellbeing;[180,193,224,225,231,232] however, further research is needed to help resolve some existing controversial issues.[225] For example, although women seem to be more resilient than men, the rate of depression and anxiety is higher amongst women.[228] Moreover, while many studies consider resilience as a protective factor that enables women to

maintain or promote their health status,[178,186,202,209] hardly any research has focused on understanding how resilience mitigates the adverse resettlement experiences of refugee women.[226]

2.2.4.1 Limitations

This review provides a broad overview about refugee and asylum seeker women's living condition, health status, and their ability to overcome resettlement difficulties globally. The review amalgamates the experiences of refugee and asylum seeker women, while as mentioned in Section 1.1, refugees and asylum seekers have different living and health status. Due to undetermined residency status and living in a situation of instability, asylum seekers may be at higher risk of facing adverse experiences and health status.[233] Further research focusing on asylum seekers' lived experiences is required to explore how this population perceives their living conditions and health status, and how they respond to the difficulties to maintain their health and improve their integration into host societies.

2.2.4.2 Recommendations

There is a need for targeted policies and services to support the capacity of communities empowering refugee and asylum seeker women with social and cultural supports. Providing health information and services, such as counselling, can enable these women to appropriately identify and seek professional help in a timely manner. Culturally and linguistically appropriate mental health support groups can provide a platform for refugee and asylum seeker women to share their experiences and burdens and attain social support from individuals who share common experiences and challenges. Further qualitative studies are needed to explore new challenges that refugee and asylum seeker women confront during resettlement and ways to overcome barriers.

2.2.5 Conclusions

The findings of this review suggest that cultural, social and material, and personal resources of refugee and asylum seeker women are lost during the different phases of migration.[195] Yet, helping these women to appropriately identify and apply culturally appropriate resilience facilitators can improve the resettlement and mental health of this vulnerable population. It is recommended that resilience factors be incorporated into the RBM to help depict a more complete picture of forced migrants' challenges and resilience strategies. In addition, understanding refugee and asylum seeker women's goals, needs, and demands and using this knowledge to inform immigration policy can help improve care and outcomes for this vulnerable population.

Table 0.1: Summary of included peer-reviewed articles

Author	Country	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Drummond et al. (2011)	Australia	To determine whether highly stigmatised health problems create particular barriers for healthcare utilisation in resettled refugees, and to ascertain whether age, level of education, or duration of resettlement might influence help-seeking pathways or barriers to healthcare	51 west African refugee women and 100 Australian women were recruited by invitation from the social network of eight West African survey administrators (African women) Undergraduate psychology students each recruited 12-15 female adults (Australian women)	Demographic questionnaire: the questionnaire was part of a large survey initiated by a group of women from the West African community in Perth who were concerned about HIV and other disease spreading within their community	Barriers to access healthcare services: - Interpersonal barriers (feeling too embarrassed or ashamed, afraid of others' thinking, afraid of being judged, fear of losing their job or being hospitalised, pessimism, a sense of personal control); increasing years of residence in Australia contributed to increase the thinking about no money, no time, the distance to healthcare services - Australian women: older less-educated women were more likely than younger more-educated women to approach a medical practitioner to manage stress - Feeling ashamed or embarrassed, fear of other's thinking, fear of losing their job	Quantitative	Medium
Hashimoto and Rose (2011)	Australia	To explore Sudanese refugee women's perceptions of the program and ongoing resettlement needs for future service development	12 adult women were recruited from an 8-week program at the Mamre Homestead	Group interview Interview questions were based around exploring the issues in resettlement to determine participant needs, including respite, language needs, employment and access	Key stressors raised include: Acculturation, housing difficulties, developing language skills, lack of employment opportunities and family separation	Qualitative	High

Author	Country	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Casimiro et al. (2007)	Australia	To explore resettlement issues of Muslim refugee women during their first five years of arrival	80 Muslim refugee women (35 Iraqi, 34 Sudanese and 11 Afghan) were recruited by purposive sampling	Semi-structured interviews Focus group with 30 participants Questions were based on the participants experiences over resettlements years and their needs	The main issues: - English language competency: poor language was seen as a significant barrier to employment, feeling isolation, loneliness and depression - Economic and job security: lack of recognition of overseas qualifications, lack of financial resources to upgrade qualifications, discrimination, poor understanding of job network and lack of understanding of religious beliefs and practices - Gender and spousal influence - Security and fear: media, racism and discrimination	Qualitative	High
Levi (2014)	Australia	To explore Sudanese refugee women's narratives around parenting teenagers in the resettlement environment.	17 Sudanese refugee women	In-depth interviews	Loss of children Loss of parenting authority New ways of parenting included talking more to children, and mutual conversation.	Qualitative	High
Schweitzer et al. (2006)	Australia	To explore the impact of pre-migration trauma, post-migration living difficulties and social support on the current mental health of resettled Sudanese refugees	63 (21 female, 42 male) were recruited by Snowball sampling by bilingual community workers	Demographic and social characteristics The Harvard Trauma Questionnaire Hopkins Symptom Checklist-37 Post-migration Living Difficulties	- Social support leads to wellbeing mentally - Support from ethnic community is the most important form of support - Pre-migration trauma, family status and gender influence mental health outcomes	Quantitative	Medium

Author	Country	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Vromans et al. (2018)	Australia	To explore lived experiences of recently-resettled refugee women-at-risk in Australia.	10 African and Afghan refugee women	2 focus groups	Main themes emerged as: Isolation, feeling incapable, feeling distress, financial hardship, and anticipating the future. Resilience factors included avoiding traumatic memories, sharing experiences, sentiment of gratefulness, and spiritual fulfilment	Qualitative	High
Goodman et al. (2017)	The United States	To explore refugee and undocumented immigrant women's experiences of trauma and stress and the ways in which they develop resilience to cope with these experiences	19 refugee women	Individual in-depth interviews.	Intimate partner violence Sexual abuse from family members Limited available material resources Family separation created a sense of regret and loss and mental disorders Feeling shame and sadness, loss of dignity of underemployment Formal support from the government is helpful in settlement and integration Resilience factors, such as avoidance, social support, community support	Qualitative	High
Pavlish (2007)	The United States	To examine meaningful life experiences as narrated by women and men Congolese refugees residing in a refugee camp in Rwanda	29 adults (15 men and 14 women) were recruited by purposive sampling	In-depth interviews (2 stages) Participants were asked to describe memories and anecdotes about significant events in their past and present lives	- Leaving a good life behind - Worrying about their daughters - feeling ambivalent about marriage - Lacking hope	Qualitative	High

Author	Country	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Pavlish (2005)	The United States	To describe a collaborative capacity building experience with refugee women	100 refugee women were recruited by purposive sampling	Three focus groups	- Poverty: the most significant issue that affects refugee women's health by leading their husbands to high-risk sexual behaviours - Struggle to survive - Overburden of family work - Ambivalence of family planning - Lack of freedom to express themselves	Qualitative	High
Watcher et al. (2016)	The United States	To identify and understand the challenges, risks, and strengths of adult Congolese refugee women resettled in the United States	57 refugee women	In-depth interviews and focus groups	Five common experiences: Significant trauma, safety and security, isolation, disempowered and overwhelmed, and precarious survival	Qualitative	High
Keygnaert et al. (2012)	Belgium and the Netherlands	To explore the nature of sexual gender-based violence that refugees, asylum seekers and undocumented migrants experienced To discuss which perceived risk and preventive factors may be considered decisive determinants for the prevention of SGBV	223 participants (132 in Belgium, 91 in the Netherlands) were recruited by purposive sampling	Questionnaire: Socio-demographic data (closed questions) Sexual health, personal or close peer SGBV experiences since arriving in Europe and prevention of SGBV (open-ended questions)	- Emotional-psychological violence led to isolation and depression - Socio-economic violence led to loss of social support - Physical violence led to permanently or temporarily injured, committing suicide - Sexual violence led to HIV and sexual disorders, unwanted pregnancy, miscarriage	Mixed method	High

Author	Country	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Ahmed et al. (2017)	Canada	To understand refugee women's experiences of having a baby in Canada from a mental health perspective	12 Syrian refugee women	A single focus group discussion The Edinburgh Postnatal Depression Scale (EPDS) 3-item anxiety subscale of the EPDS 4-item Primary Care PTSD screening tool The short form of Women Abuse Screening tool (WAST)	Stigma of mental health and privacy concerns prevent people from seeking mental health services Financial support, housing, and medical care from the government reduce mental health issues Coping strategies such as physical exercise helps in maintaining mental wellbeing Poor language impairs their mental health help seeking	Mixed method	High
Floyd and Sakellariou. (2017)	Canada	To explore the experience of both barriers to care and the facilitating factors that the women utilised in order to gain access to healthcare	Eight non-English-speaker refugee women	semi-structured interviews, two interviews with each participant	Poor English language resulted in: Dependence, Isolation, fear in navigating the healthcare system, sense of shame, and rejection. Some resources such as refugee clinics, using volunteers, using visual memories to find their way to the clinics were helpful.	Qualitative	Medium

Author	Country	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
O'Mahony and Donnelly (2013)	Canada	To explore how cultural, social, political, historical and economic factors intersect with race, gender and class to influence the ways in which immigrant and refugee women seek help to manage Post-partum depression	30 women (8 refugees and 22 immigrants) were recruited by purposive sampling	In-depth interviews Semi-structured questions The questions address: How do socio-cultural, political, historical and economic factors influence refugee women's mental health? And what services or strategies could address mental disorders?	- Immigration status (unable to work, limited access to healthcare services, low income, no access to language classes and housing, family separation, insecure immigration status, fear of returning) affects their emotional wellbeing and self-esteem - Precarious immigration status leads to vulnerability regarding to sexual, physical and economic exploitation - Dependency on third person may leave women with limited access to information about their rights, at risk for domestic abuse, socially isolated and plagued with overwhelming fears of being deported and separated from their infant - Shifting roles within the family (stay at home) leads to PPD	Qualitative	High
Schubert (2011)	Finland	To examine the role of culture, refugee status and gender in the mental and somatic health amongst help seekers in a centre for torture survivors in Finland	78 adults (29 women, 49 men) were recruited by sequential sampling of patients who had appointment with the staff in the Helsinki Deaconess Institutes' Centre for Torture Survivors in Finland	Impact of Event Scale-Revised (PTSD) Hopkins Symptom checklist-25 (Depressive and anxiety) Patient chart information (somatic complaints) Harvard Trauma questionnaire (Exposure to trauma)	- There are no significant main effects of the legal status on symptoms of PTSD, depressive and anxiety - Gender is a significant covariance for PTSD	Quantitative	High
Usta and Masterson (2015)	Lebanon	To examine the relation between refugee status, reproductive health outcomes, and domestic violence.	452 Syrian refugee women	Individual interviews and 3 focus groups	Loss of material resources such as food, water, toys for children, accommodation Mental and physical poor health Concerns for family left behind Intimate partner violence	Qualitative	High

Author	Country	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Tappis et al. (2012)	Syria	To assess a variety of health and wellbeing measures amongst the Iraqi population in Syria	486 adult women recruited by stratified cluster sampling	A household questionnaire One-page form of domestic violence (physical, verbal and emotional abuse)	- Verbal abuse was the most common form (56%) - Physical violence (34%) and emotional abuse (20%) - Women reporting some financial difficulties during the first month after arrival in Syria were 68% less likely to have recently experienced violence than women who reported being financially comfortable upon arrival	Quantitative	High
Svensson et al. (2017)	Sweden	To explore the experiences of newly arrived refugee women with regard to exposure to the health education in sexual and reproductive health	9 refugee women from Iran, Afghanistan, Somali	Face to face interview	Easier access to sexual health information Better communication with husbands and other men	Qualitative	Medium
Whittaker et al. (2005)	The United Kingdom	To explore how young Somali female asylum seekers and refugees, growing- up in northern England (a white, Western host culture) understand psychological wellbeing To explore their individual and interpersonal or collective perceptions	5 adult women recruited from a voluntary sector Somali training and community centre in northern England	3 focus groups 5 individual interviews	- Supporting resources: Family and community, religion and services - Socio-cultural problems: Conflicts and convergence, navigation and acculturation - Concealment: Concealing concepts and emotions, secrets, confidentiality and trust	Qualitative	High

Author	Country	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Catolico (2013)	The United States	To define health from the perspective of Cambodian women in the context of resettlement To identify the conditions or circumstances that influenced their perception of health	39 refugee women in various ages were recruited from Community contacts by snowball sampling	Open-ended questions The question addressed the perceptions of health of Cambodian women in resettlement	- Strategies of coping: Achieving spiritual fulfilment, re-establishing kinship, engaging in meaningful work - Experiences: Loss, leaving behind, work and family life - Caring for oneself: - Following tradition and integration option - Consequences: Disharmony and harmony	Qualitative	High
Perera et al. (2013)	The United States	To assess differences in pre-migration, transit, and resettlement stressor exposure and PTSD symptoms as a function of demographic characteristics (i.e. gender, ethnicity, age, time in the United States) To examine the concurrent and longitudinal relationships between stressor exposure and PTSD symptoms	437 refugees from Oromo and Somali (115 Somali women, 98 Oromo women) were recruited from two previous cross-sectional studies with purposive sampling and lengthy recruitment	The pre-migration stress scale was a 20-item scale The transit stress scale The resettlement stress scale consisted of 16 items The PTSD Checklist–Civilian (version 17 self-report items) Open-ended question was about the most stressful events have been experienced during resettlement	- Pre-migration, transit and resettlement stressors result in PTDS - PTDS was more common amongst men than women	Qualitative	High

Author	Country	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Baird (2012)	The United States	To present a situation-specific theory of wellbeing in refugee women experiencing cultural transition	7-11 women in each focus group	Focus groups The questions were: How do Sudanese refugee women conceptualise wellbeing? What do Sudanese refugee women identify that facilitates wellbeing during the resettlement transition? What do Sudanese refugee women identify that inhibits wellbeing during the resettlement transition?	- 3 phases of cultural transition: separation, being between two (old and new) culture and integration lead to enhanced or diminished wellbeing - Facilitators are: education, ethnic community support, religion and English language skills - Inhibitors: divorce, lack of education, lack of language skills and conflict between law and traditional culture	Qualitative	High
Nilsson et al. (2012)	The United States	To increase the understanding by interviewing Somali mothers about the adjustment of Somali children	24 women 22-58 years of age were recruited from a local organisation that serves refugee and immigrant women	Semi-structured and open-ended questions such as what do you see as the main problems facing you in your community? Demographic information	- Women presented their experiences in five themes: Cultural comparison, concerns about children, parents' loss of disciplinary authority, available support and the future	Qualitative	High

Author	Country	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
McBrien (2011)	The United States	To gain insight into Somali, Vietnamese and Iranian women's experiences with resettlement and school involvement	22 mothers (7 Vietnamese, 7 Somali and 8 Iranian) were selected after the first survey by HRF members (Health for refugees' families) purposefully	Focus group Open-ended questions	- Vietnamese mothers: language barrier, rape in camps, no discrimination, appropriate schools - Somali mothers: language barrier, hardship in camps (inadequate food and education, danger and heat), taunting at school, English insufficiency leads to underestimating discrimination - Iranian mothers: taunting at school, discrimination at work and school, language barriers, cultural barriers, free relationship between girls and boys, sexual permissiveness, illegal drug access	Qualitative	Medium
Brown et al. (2010)	The United States	To explore the relationships between selected demographic variables and three dimensions of mental health (general distress, somatic distress and performance distress)	83 adult women were recruited by purposive sampling from a Vietnamese community centre, a Vietnamese Buddhist temple and an international women's institute	The Hopkins Symptom Checklist-21 Demographic questionnaire (age of arrival, English proficiency, length of stay, income, relationship status, parenthood, education level, religious affiliation)	- Poorer English proficiency leaded to grater general and somatic distress - Women with older age of arrival reported greater somatic distress - No relationship between income and mental health - Women with more children and less-educated reported greater forgetfulness and worries about accurate and thorough task completion	Quantitative	Medium

Author	Country	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Nilsson et al. (2008)	The United States	To examine the relationships between acculturation, domestic violence, and mental health in married refugee women from Somalia	62 married women were recruited through an organisation that supports the adjustment of refugee and immigrant women	Hopkins Symptoms checklist-21 Conflict Tactic scale 2 Demographic information Acculturation (speaking English, time spent in the US and the number of American friends)	- Women with greater proficiency in speaking English were more likely to experience both psychological and physical abuse from their partners	Qualitative	High
Sossou et al. (2008)	The United States	To focus on Bosnian refugee women's experiences as refugees and the factors that contributed to their resilience	7 refugee women were recruited by purposive sampling by sending invitations to participants who attended the previous quantitative study	Face-to-face interviews Open-ended questions Questions addressed their general wellbeing before their flight from Bosnia; their families and children and their mental well- being; their spirituality and religion; and the challenges of resettlement in a new country	- Personal experiences and challenges with resettlement consist of language barriers, lack of public transportation, lack of instant educational opportunities and misconceptions about accessing mental health services - Shocking experiences consist of loss of occupational status, family disconnection and cultural changes in the new country - Resilience factors included family and spirituality (not religion, belief in a higher power)	Qualitative	High

Author	Country	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Carroll et al. (2007)	The United States	To learn more about Somali women's health experiences in order to improve healthcare for Somali women	34 adult women were recruited by snowball sampling	In-depth interviews One focus group consisted of 6 women Questions were around the Somali women's beliefs about health promotion; and what do Somali women know about common health services in the United States that detect or prevent disease	- The important themes to be healthy: hygiene and sanitation, adequate nutrition and exercise, traditional healthcare networks, remedies and rituals, religion, access to healthcare and medications, and knowledge about the US healthcare system - Conceptual themes: Participants generally considered themselves healthy, focus on survival, good health as a key priority, improved opportunity for education, freedom.	Qualitative	High
Freedman (2016)	Germany	To document the various forms of sexual and gender-based violence experienced by women refugees	40 asylum seeker and refugee women	Face to face interview	Sexual violence from intimate partner No help from police and social workers Inadequate accommodation increased women's vulnerability gender-based violence	Qualitative	Medium
Bradby et al. (2015)	World Health Organisation	To explore public health aspects of refugees and asylum seekers in the European Region	Not mentioned	Databases of the Cochrane Library, Web of Science, ProQuest, PubMed, Science Direct and the National Centre for Biotechnology Information, and grey literature	Barriers in accessing health services include communication difficulties, gender preference for doctors, transpor social insurance systems. Access to specialist was difficult too A good resettlement is associated with better health outcomes	Literature review	High

Section 2.3 presents the second literature review that aimed to explore the impact of migration on the health status of Iranian immigrants. The review also focused on Iranians as a specific culture, as detailed in Section 1.4, and helped the researcher to explore challenges that Iranian immigrants specifically encounter during resettlement in the host countries. Findings of the review were collated with the previous literature review to further develop the current study's research questions and discussion of the study findings.

Similar to the previous article, this paper is presented in its preprint form with its published version in Appendix 6. The article is cited as: Shishehgar, S., Gholizadeh, L., DiGiacomo, M. & Davidson, P. M. 2015. The impact of migration on the health status of Iranians: An integrative literature review. *BMC International Health and Human Rights*, 15, 20. The BMC series, as open access publishing, has evolving peer-reviewed journals including *the BMC International Health and Human Rights,* which considers articles relating to the impact of health policies, programs and practices on human rights. Due to its international and open access nature, the published article is freely and permanently accessible online. Therefore, a wider audience can reach the work. The impact factor of this journal for the last five years was 2.182.

2.3 The impact of migration on the health status of Iranians: An integrative literature review

2.3.1 Background

Immigration, whether voluntary or forced, is increasingly driven by social, political and economic factors. As a consequence, some discussions and debates have emerged on the impact of migration on health status of immigrants.[118,234] For generations, people have

left their homelands and resettled in other countries seeking better futures.[212] Such transitions can be challenging and may contribute to social marginalisation, loss of social networks,[235-237] healthcare access issues,[238] and adverse health consequences, including depression and anxiety.[239-242]

Events such as the Islamic revolution, political changes, war, and international sanctions have compelled many Iranians to flee their homeland over the last four decades.[243,244] As a result, Iranians comprise a significant proportion of immigrants departing from the Middle East.[212,244-247] The number of Iranian immigrants in Canada indicates a significant growth rate of 147% from 1996 to 2006.[248] In addition, it is evident that more than 200,000 highly educated individuals fled Iran to Australia, Canada, Eastern Europe, and the United Arab Emirates in the years after 1990 due to economic factors.[249]

The increasing trend of migration of Iranians has provided the impetus for focusing on the process and outcomes of migration for this specific population. Yet, to date, there is limited research and information available that describes Iranian immigrants' experiences of migration and their health outcomes.[234,244,250,251] The available evidence suggests that Iranian immigrants are at risk of mental health problems. For example, the results of a study in Germany showed a significant high prevalence of mental health disorders resulting from acculturation stress in Iranian immigrants,[252] but further understanding of factors involved in succumbing to or preventing acculturation stress is unavailable. Without such an understanding, the needs of this group will remain unmet, leaving them vulnerable to adverse health outcomes in their new homelands.

The aim of this integrative review was to ascertain information about Iranian immigrants' resettlement experiences and health outcomes for the purpose of informing design and delivery of services and prevention of adverse effects of migration. Although there has

been much written about the health outcomes of immigrants, this review focused on the unique contextual experiences relevant to Iranian immigrants.

2.3.2 Methods

2.3.2.1 Search strategy

The search strategy was designed in consultation with a health librarian. Electronic databases searched were Medline, CINAHL, ProQuest, Academic Search Complete, Scopus, PsycINFO, and the Google Scholar search engine. Reference lists of the relevant literature were also reviewed for further related studies. Keywords used in the search were terms that depicted the person or event of migration (immigra*, migrant*, emigrant*, exile, refugee*, asylum seek*, displace*), the origin country (Iran*, Persia*) and health-related outcomes (health, mental health, psychological).

2.3.2.2 Selection of studies

Peer-reviewed and grey articles were included if they were written in English and published after 1980. This date was selected as it paralleled the first major wave of Iranian migration.[244] The review included studies of any design, involving Iranian immigrants departing their country for any reason, voluntary or forced, and who were settled in a host country. Articles that focused on people from different nations were also included if they reported the experiences of Iranian immigrants separately when presenting the results. Articles were excluded if they did not focus on Iranian immigrants. Articles that focused on physical health issues without any consideration of the influence of immigration were excluded. The search strategy of this integrative review was guided by the principles of the PRISMA.[253] Titles and abstracts of retrieved studies were reviewed to assess whether they met inclusion criteria. If inclusion was not immediately clear, full texts of articles were reviewed.

2.3.2.3 Data management and extraction

The first author (SS) extracted data from articles that met inclusion criteria and inserted information regarding aims, sample size, research instrument, main findings, type of study, and quality of study into an Excel spreadsheet to allow for tabulation and comparison across studies. A summary table was used to depict key themes and findings of included articles (Table 2.2, presented at the end of this chapter). The first author (SS) independently discussed data extraction with the two other authors (SS-MD, SS-LG). Any disagreements were resolved through discussion until consensus was reached.

2.3.2.4 Quality assessment and data analysis

The first author (SS) assessed quality of the included articles using CASP as presented in Table 2.2. Only one article was found to be low quality; however, it was not excluded due providing important information about Iranian immigrants' mental health compared to Russian immigrants as two culturally different immigrant groups in Germany.[254] The studies were divided into qualitative, quantitative and mixed method studies. A thematic analysis approach was used to derive themes from the findings of the included articles. Since some included articles presented results for multiple nationalities, the preliminary analysis grouped the extracted themes according to immigrants' countries of origin. When presenting the findings, results depicting only Iranian immigrants were included in this review article. Extracted themes and inconsistencies were discussed amongst the authors (SS, LG, MD, and PMD) and consensus made.

2.3.3 Results

Following application of inclusion and exclusion criteria and removal of duplicates, 31 articles were included in the review (Figure 2.3).

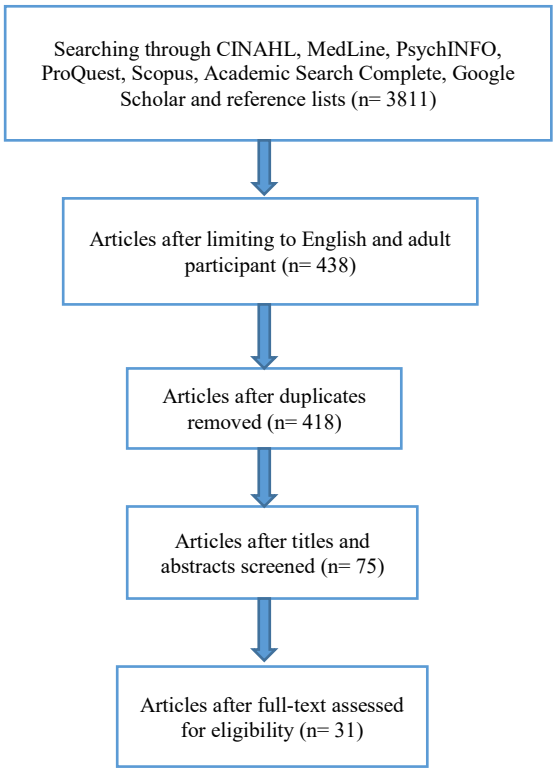

Figure 0.3: PRISMA flow chart of search process

Of 31 included articles, 19 studies were quantitative, 10 qualitative and two mixed methods (Table 2.2). Data collection methods included focus groups, face-to-face interviews, and cross-sectional surveys. Qualitative studies depicted the experiences of Iranian immigrants and the impact of these experiences on their health status. Quantitative studies mainly reported on the prevalence of negative experiences of migration, resettlement in host countries and their associations with mental health disorders. All included studies were conducted in Western countries such as Sweden, Canada, and the USA. Themes derived from the articles reflected the socio-cultural experiences during three phases of migration – pre-migration, transit, and post-migration (Figure 2.4). [114,255-263]

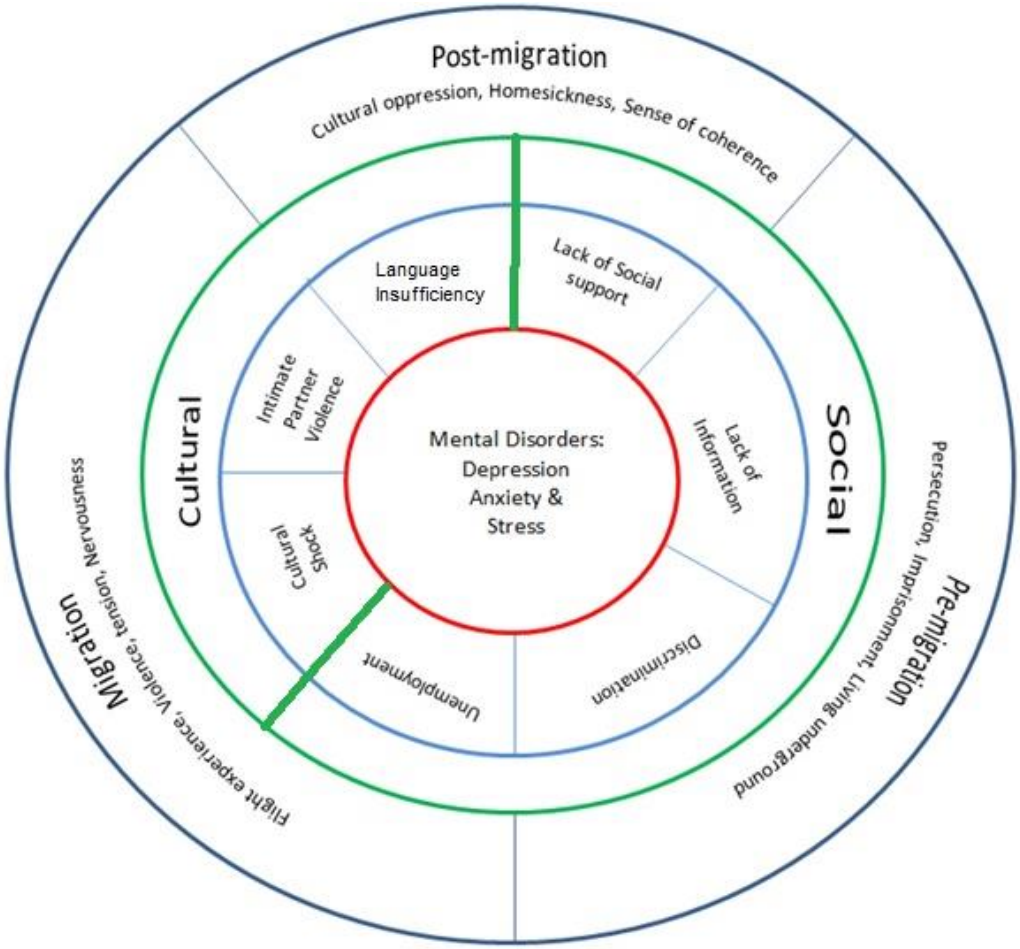

Figure 0.4: A framework of concepts pertinent to Iranian immigrant experiences, derived from the review of literature

2.3.3.1 Qualitative and quantitative studies

The included qualitative studies used face-to-face interviews or focus groups to collect data. Audio recording was refused by participants in one study because of previous experiences of information gathering for political purposes and resultant distrust.[264] In line with the importance of assurance about maintaining anonymity and confidentiality as a paramount ethical consideration in particular in qualitative research, 14 studies including qualitative data provided explicit statements regarding this ethical concern.

In quantitative studies, cross-sectional data were collected predominantly via close-ended questionnaires administered via face-to-face interviews. Two studies asked respondents

to complete questionnaires using web-based survey platforms or via telephone interview.[262,265]

Findings of the included studies revealed seven sub-themes under the two main themes of social and cultural issues. The themes and sub-themes represented common problems faced by Iranian immigrants during migration and throughout the settlement process in the host countries. Figure 2.4 presented the main themes and sub-themes.

2.3.3.2 Social issues

Employment: Inability to find employment commensurate with qualifications was identified as an important stressor that Iranians experienced in their new countries. Underemployment and unemployment contribute to low self-esteem and self-confidence in Iranian immigrants, who were previously proud of their prominent employment roles in their home country.[264,266] Lipson (1992) highlights that even highly skilled Iranian professionals could not find a suitable job upon arrival to the USA.[267] Unemployment and underemployment, in general, have been linked to insecure economic conditions, high stress levels, depression, anxiety, and other mental disorders.[244,261,267,268] A study by Khavarpour (1997) on 161 Iranian immigrants residing in Sydney, Australia, reported that those who lost their employment and social status were more likely to experience psychological distress.[265] Khatibsemnani (2014) further argued that employment enhanced Iranian immigrants' sense of belonging to Canada and facilitated their access to support services in this country. The author added that unemployment not only leads to income insecurity and poverty, but also affects the immigrants' identity formation, which has a direct impact on their mental wellbeing.[266]

The value of employment was exemplified by Iranian women in Canada, who conveyed that a meaningful occupation can mitigate painful experiences of immigration, such as

separation from their children.[244] In contrast, Moztarzadeh and O'Rourke (2015) failed to find a direct link between loss of occupational status and depressive symptoms amongst Iranian elderlies in Canada.[269] The inconsistency may be related to the different socio-demographic characteristic of the studied populations, in particular the differences in age.

Utilisation of healthcare services: Limited knowledge about healthcare services was another obstacle that Iranian immigrants often face upon arrival to host countries. Lack of awareness of healthcare services was found to delay and inhibit health-seeking activities of Iranian immigrants, and may exacerbate their existing health condition.[256,266] In some countries, such as Canada, immigrants are provided with many forms and pamphlets about daily living needs including information about available healthcare services. In some cases, these resources have been described by Iranian immigrants as being too long and difficult to understand[256] while others found the posters and pamphlets useful.[266]

In addition, poor language proficiency was found to affect immigrants' access and utilisation of healthcare services. A study on Iranian immigrant women in Canada revealed that using children as interpreter brings a sense of discomfort for the parents to explain their mental or physical health issues.[266] The expenses of medicines, consultation, and other services, such as dentist and allied health services, also hindered access to the services. In the same study, the participants critiqued the health care system in Canada for lack of same-sex health providers, long waiting lists, and inefficient referral system.[266]

Access to healthcare services is critical in addressing the mental health problems of immigrants. Results of a study showed that approximately 28% of Iranian immigrants in Germany were suffering from untreated mental health disorders due to a lack of access to appropriate mental health services.[252] Likewise, Neale et al. (2007) reported that

confusion around and lack of adequate information about the healthcare system in Australia contributed to exacerbation of mental health issues among Iranian immigrants.[270]

Lack of social support: Support from family and friends and a social network helps mitigate the adverse impacts of migration-related stressors, such as unemployment and poor language skills.[265,266] However, many Iranians lose this source of support by leaving their family and friends behind in their country of origin. On the other hand, Lipson (1992) describes Iranians as a multicultural, multi-language, and a multi-religion population, who are not frequently part of a cohesive homogenous social network.[267] Therefore, they perceive it as challenging to build a supportive social network during resettlement in a host country. In line with this assumption, Meleis et al. (1992) conducted a comparative study on immigrants from five different Middle-Eastern immigrant groups, including Iranians residing in the USA. They reported the lack of an ethnic community for Iranian immigrants contributed to in the higher rates of depression and mental health issues in this immigrant group.[259]

A study in Sweden found that 72% of Iranians had a social network; however, the remaining subset (28%) reported poor social networks and associated poor social support and mental health.[268] A recent study on international Iranian students in Australia, however, reported a lower r rate of distress and mental disorders amongst this population compared to the previous studies.[260] Nahidi et al. (2018) suggested the differences may be related to stronger social networks among students and social connectedness with Iranian communities. Further, international students are more likely to have a secure residency status, better proficiency in English language, and less likely to face the difficulties that Iranian refuges or immigrants face in the society.

Sense of discrimination: Iranian immigrants reported experiencing discrimination. 11 of the 31 studies considered discrimination to be a significant factor leading to depression and mental health disorders in Iranian immigrants.[24,261,264,266-268,271-275] In a study, 60% of Iranian immigrants living in Sweden had perceived ethnic discrimination.[268]

A qualitative study in Canada reported a perception of racial discrimination by Iranian immigrants due to their Middle-Eastern" appearance, accent, names, and type of dressings.[266] In contrast, Moztarzadeh and O'Rourke (2015) reported that less than 2% of Iranian immigrants experienced overt discrimination, while 7% perceived subtle discrimination at work due to their ethnicity or religion. Experience of discrimination can increase the risk of mental health issues. A quantitative study on Iranian immigrants in Australia revealed a significant correlation between perception of discrimination and depressive symptoms.[276] Hosseini et al. (2015) discussed that socio-demographic variables, such as being younger and unmarried, shorter length of residence in Australia, lower education, unemployment, and perception of discrimination contributed to risk of mental disorders in Iranian immigrants.

Wiking et al. (2004) found that 34% and 51% of Iranian men and women, respectively, experienced discrimination when using healthcare services in Sweden.[274] However, Martin (2012) did not report any forms of discrimination against this ethnic minority from healthcare providers and physicians in the USA.[24] However, experience of discrimination in educational centres, such as schools and English language institutions has been reported by Iranian immigrants in studies carried out in the USA and Canada.[261,272] Some immigrants reported that they were judged negatively on their religion and English accent.[261]

2.3.3.3 Cultural issues

Communication barriers: Learning the host country's language is an important factor in successful integration into the host society.[277] It seems that inability to communicate in English affects all aspects of Iranian immigrants' lives, including involvement in social activities and building a relationship with the host society. Poor language skills has been related to communication difficulties, protracted resettlement and acculturation stress resulting in frustration and loneliness.[255,263] The adverse experiences may contribute to social isolation, anxiety, and depression.[212,263,266,278] In addition, impaired mental health can challenge one's adjustment and language acquisition.[263] Steel et al. (2011) found that English language skills of refugees with a PPV was better than refugees with a TPV.[263] They add that psychological distress emanating from post-migration difficulties associated with holding a TPV decreases the individuals' capacity to acquire language skills. In contrast, those with a PPV demonstrated a significant improvement in their language ability, engaged in social activities, and integrated well into the host society.[263] Khatibsemnani (2014) reported inability to afford for language classes expenses, work limitations, and limited scheduled classes as barriers to learn English by the Iranian immigrants in Canada.[266] Collectively, the available evidence suggests a pattern of increased mental distress amongst Iranian immigrants with low levels of host language proficiency.

Cultural differences in non-verbal communication may further hinder the social interactions of Iranian immigrants. A qualitative study by Arbabi et al. (2017) revealed that Iranian immigrants were surprised and confused when faced different body languages such as eye contact or smile from their Malaysian peers. For example, one participant said *"when I say to them "Hi," they just look at me with a smile!".*[255]

Another communication barrier is related to cultural differences in reacting to problems. For example, Iranians culturally over react to problems and take immediate actions when facing a problem while Malaysian people are more relax and do not focus on the problem.[255]

Culture shock: Culture shock is defined as differences in expectations, values, and social norms that might be experienced by immigrants through their social interactions in Western countries.[267,271,273] Divergent cultural norms, which are mostly difficult to deal with effectively, can result in conflict between parents and children, child-rearing styles, relationship breakdown, and divorce.[244,258,267] Inability to adjust to cultural differences can contribute to stress and depression in Iranian immigrants.[274,279,280] Ghaffarian (1987, 1998) in her quantitative studies on Iranian immigrants in the USA found a relationship between acculturation and mental health disorders. She reported that Iranian immigrant men participated more in the host country culture compared to their women counterparts. Ghaffarian concludes that higher acculturation of the men resulted in better mental health.[279,280] However, this finding is still controversial. Cultural differences can also influence immigrants' health-seeking behaviours. Some immigrants experience numerous communication problems, not only because of their English language deficiencies, but as a result of cultural misunderstandings where healthcare providers misinterpret immigrants' discomfort or distress.[267,281]

Another cultural difference between Western countries and Iran relates to sexual content in the media and community. Many Iranian women in these countries are concerned about the effects of these exposures on their relationship with their husband and resultant expectations.[24]

Arbabi et al. (2017) undertook a qualitative study on Iranian immigrants in Malaysia. The participants were asked about the challenges that they confronted during resettlement in the host country. Living in a multicultural country, they had to communicate with people from various ethnicities, religion, and beliefs. For Iranian immigrants who come from a country where people follow a general Iranian and Islamic culture, it was confusing to deal with multicultural features of the society. The sense of confusion and lack of skills to communicated with people from different cultures resulted in isolation and feeling of loneliness.[255]

Intimate partner violence: Violence by an intimate partner was reported in three of the 31 articles.[257,262,264] Violent behaviours may include being kicked, slapped, dragged, shoved, forced to have sexual intercourse, beaten, and restricted from attending social activities.[257] An Iranian woman in Sweden reported that her husband did not allow her to go to work or attend classes. Consequently, she divorced him to maintain her dignity and mental wellbeing.[264] Several studies found that exposure to family violence was strongly associated with self-reported mental health problems of Iranian immigrants.[257,262,264] Guruge et al. (2012) report that one-third of Iranian immigrant women participating in their study were suffering from mental illness due to violent behaviours from their intimate partner.[257]

2.3.4 Discussion

This review highlighted the challenges that Iranian immigrants encounter during resettlement in host countries, and the impact of associated negative experiences on their health and wellbeing. The results of this review revealed that migration may contribute to adverse psychological outcomes. These data contributed to development of a conceptual framework that addresses the main challenges faced by Iranian immigrants

across pre-migration, transit, and post-migration phases and how these experiences affect the immigrants' mental health, including experience of stress, anxiety, and depression (as previously illustrated in Figure 2.4).

The conceptual framework reflects social and cultural issues related to immigration, contributing to mental health problems amongst the Iranian immigrant population. Social issues, including experiences of discrimination, utilising healthcare services, lack of social support, and unemployment, can have adverse effects on immigrants' health and successful integration into the host society. Similarly, cultural issues including communication barriers, intimate partner violence, and culture shock are likely to increase risk of developing psychological problems. These key factors are discussed in relation to the health of immigrants. The communication barrier has been considered as a social issue in the literature; however, in line with the RBM, which was discussed in the previous publication presented in Section 2.2, the authors categorised it as a cultural issue that hampers Iranian immigrants' successful integration into the host culture.

The challenges identified in the literature appear relevant to many immigrant populations; however, Iranian immigrants are likely to be particularly at higher risk for mental health disorders. Pre-migration experiences, such as the Islamic revolution of Iran, the eight-year Iran-Iraq War, and the recent economic sanctions against this country can negatively affect Iranians' mental health.

The findings of this review also suggest that communication barriers hinder effective interaction of immigrants with mainstream communities, leading to social isolation, and lack of utilisation of social services, including healthcare services.[24,212,244,261,263,267,270,272,282] These negative experiences have been linked to exacerbation of mental health problems in this population.[283] Yet, healthcare providers

do not perceive linguistic limitations as a barrier to the use of healthcare services and poor health status of immigrants.[256] From the point of view of healthcare providers, cultural misunderstanding and lack of awareness of healthcare services are more important factors that can result in dissatisfaction with healthcare systems rather than language insufficiency.[256] A study by Tyndale et al. (2007) on Iranian immigrants residing in Canada revealed cultural diversities as the main barrier in accessing healthcare services, in particular sexual health services.[281] These two studies suggested a culturally and linguistically friendly source of information, such as an informative health-related website in both Farsi/Persian and English languages, to assist patients meet their health inquiries. In addition, empowering and educating Iranian immigrants through holding workshops on health topics, in particular mental health issues, can help this population to attain adequate and effective access to healthcare services. Moreover, building strong ties with the community and providing Farsi/Persian speaking telephone assistance can facilitate a more accessible resource to answer their health-related questions.[256,281]

Another migration-related factor that influences the health of immigrants is their employment status. Almost all studies in this review assert that unemployment and underemployment are common challenges that Iranian immigrants endure over resettlement in host countries.[244,261,264,267,268,272] These studies depict the negative effects of unemployment on mental health of immigrants, such as reduced self-esteem and self-confidence and high levels of stress, anxiety, and depression. Unemployment is particularly problematic for Iranian immigrants compared to other Middle-Eastern immigrants, as immigrants from Iran are more likely to be highly educated and possess high social standing in their origin country. The inverse relationship between education

and employment has contributed to poor mental health outcomes amongst Iranian immigrants.[139,262]

Generally, immigrants report lack of social support in a new country. While Iranians have been observed as a well-organised community in Sweden,[268] another study reports that Iranians do not develop a cohesive organised community.[267] This was partially related to the existing diversities in Iranian's culture, language, and religion as well as political and economic issues, which are often carried forward into immigrants' new life.[267] The inconsistency in the findings may be a result of different methodologies employed, timing, and settings of the studies. Further, the political climate that characterises different time periods possibly contributed to the diverse immigrants' socialisation and congregation behaviours. For example, the Islamic revolution of Iran, and the resultant political unrest may have influenced Iranians' behaviours at that time, resulting in limited trust and unitedness amongst Iranian immigrants.[267] After several decades of political conflict, however, Iranians may have decided to become more united to be able to help themselves and fellow immigrants in a new country.[268] Evidence reveals a direct relationship between lack of social support and mental disorders,[267,268] yet, social support cannot guarantee mental wellbeing.[232]

Many studies report the experience of different types of discriminations by Iranian immigrants, and how these negative social experiences affect different aspects of the immigrants' life, particularly their mental health.[246,264,268,272] Yet, it is argued that discrimination towards immigrants is likely to be underestimated due to language and cultural barriers.[284] Negative portrayal of Islam and the Middle East in the media is likely to affect the host society's attitude towards immigrants from Iran resulting in discriminatory behaviours. Discrimination can lead to mental health disorders, reduced

self-confidence, and social isolation, hindering acculturation and resettlement for immigrants.[282]

Apart from the social challenges, exposure to a new culture and new ways of living can be the source of considerable dissonance amongst family members, affecting their relationships and expectations from each other.[285] Iranian immigrants have been recognised as people who are willing to integrate with host cultures, but they also do not like to give up their customs.[139] In other words, Iranians carry their 'cultural baggage' as well as demographic profiles wherever they go. Preserving cultural values may result in a higher risk of separation from the host society and a higher rate of conflicts within families.[3,286]

The literature on immigrants has mainly focused on negative outcomes of migration, and overall immigrants have been portrayed in the literature as 'victims' in the migration process; however, Sulaiman-Hills and Thompson (2012) in their study on Kurdish and Afghan refugees in Western Australia and New Zealand established a new perspective on migration. They found that migration could provide educational and occupational opportunities for immigrant women.[219] Better opportunities for women are expected to improve their cultural adjustment and mental health.

Analysis of the included studies in this review demonstrate that Iranian women are at higher risk of mental health problems due to less ability to cope with the host societies' culture.[262,274] However, Moghissi (1999) in her study on Iranian immigrant women in Canada found that compared to men, Iranian women were more prepared and made more effort to successfully integrate into the host society.[282] This finding was justified by the fact that Iranian women are used to accepting changes and adjusting to changes due to their background and socio-cultural factors. For example, many Iranian women had to

live with their husband's family despite their divergent attitudes and culture. Through these experiences Iranian woman learned strategies to cope with new changes.[282]

In general, the role of gender in the resettlement process and mental wellbeing of Iranian immigrants is still controversial. The controversy may relate to the difference between Iranian populations living in different countries. For example, a significant number of Kurdish Iranians immigrated to Sweden as asylum seekers having experiences of violence, political conflict, and ethnic discrimination before migration.[274] These experiences may increase their vulnerability to psychological distress. In addition, compared to Kurdish men, Kurdish women are at higher risk of anxiety and mental health problems due to a lower sense of control over their lives.[287] Thus reports from Sweden showing Iranian immigrant women are less culturally adjusted and more mentally distressed are to be expected.

Overall, there is a shortage of studies focusing on Iranian immigrants' experience of migration and resettlement in host countries and their mental health issues, likely due to the difficulties in conducting research on minorities. Possible positive outcomes of migration, such as reaching freedom, living in a well-organised society, greater facilities, and support from host countries' governments, need to be explored by research,[219] particularly from immigrant women's perspectives.

2.3.5 Conclusion

The conceptual framework derived from this integrative review suggests that the mental health of Iranian immigrants can be affected by the challenges they encounter across pre-migration, transit, and post-migration phases of migration. Pre-migration stresses, language barriers, unemployment, lack of information about healthcare services, social

isolation, experience of discrimination, cultural shock as well as intimate partner violence can adversely affect the wellbeing and mental health of Iranian immigrants. These factors should be considered by policymakers and healthcare professionals when developing policies or interventions to improve the health of immigrants.

Table 0.2: Summary of included peer-reviewed articles

Author	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Alizade-khoie (2011) Australia	To explore the impact of acculturation on health status	N = 302 Iranians Age > 65 y	Developed questionnaire from the New South Wales (NSW) Older People's Health Survey 1999	- Iranian elderly immigrants suffer from high level psychological issues and physical activity limitation - English proficiency decreases the rate of depression and anxiety	Quantitative	High
Hosseini et al. (2015) Australia	To investigate the association between levels of depression and socio-demographic and migration variables, and the role of resilience as a mediator between these features	N = 182 Iranians	Migration and Settlement Questionnaire (MASQ), Resilience Scale for Adults (RSA), Depression Anxiety Stress Scale (DASS-21)	Higher levels of depression were found in participants who were unemployed, experienced high levels of discrimination, had an incomplete tertiary education.	Quantitative	High

Author	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Nahidi et al. (2018) Australia	To investigate psychological distress in Iranian international students at UNSW Australia To explore the psychosocial factors associated with high levels of distress.	N = 180 Iranian international students	Socio-demographic questionnaire Kessler Psychological Distress Scale (K10) World Health Organization Quality of Life Scale (WHOQOL—BREF) Attitudes towards Seeking Professional Psychological Help Scale—Short Form (ATSPPHS—SF) Multidimensional Scale for Perceived Social Support (MSPSS) Duke Religion Index (DRI)	Smaller proportion of Iranian international students scored as distressed Greater levels of psychological distress were associated with being female, poorer physical health, less social support, and negative attitudes towards seeking professional psychological help Higher level of social support associated with better mental wellbeing.	Quantitative	High
Arbabi et al. (2017) Malaysia	To investigate cross-cultural transition issues facing Iranian immigrant adolescents living in Malaysia	N = 100 Iranians Ages 14-18 years	In-depth semi-structured individual interviews Descriptive phenomenological study	Five major themes regarding participants' life experiences in Malaysia: Initial expectations Differences in ethnicity, religion, and beliefs increases isolation and psychological issues Communication barriers lead to feeling confused and alone Differences in personal evaluations	Qualitative	High

Author	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Khavarpour (1997) Australia	To determine the levels and predictors of psychological distress within the Iranians living in Sydney	N = 161 Iranians	General Health Questionnaire (GHQ-20)	- Students are more likely to report psychological distress compared to full-time workers - Migration contributes to psychological distress - Social support can reduce the experience of distress of unemployment and poor English proficiency	Quantitative	Medium
Steel et al. (2011) Australia	To examine for differences in the trajectory of psychological symptoms and key indices of social adaptation amongst refugees over two years	N = 104 Iranian and Afghan immigrants	The Harvard trauma questionnaire The Hopkins symptom checklist-25 The general health questionnaire The Penn State Worry questionnaire Post-migration living difficulties and detention experiences checklist	- Language insufficiency results in increasing mental distress, social isolation, difficulty in acculturation process, and ongoing resettlement difficulties	Quantitative	High
Neale (2007) Australia	To examine the knowledge, use and satisfaction of local healthcare services	N = 98 Iranians, Afghan and Iraqi (N = 23 Iranians)	Focus group Semi-structured questionnaire Multiple-choice questionnaire Open-ended questionnaire	- Poor English skill - Dissatisfaction with health care services	Qualitative	Medium

Author	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Kim and Noh (2014) **The United States**	To examine ethnic and gender differences in exposure to discrimination and its association with depressive symptoms among five immigrant groups	N = 900 immigrants from Iran, Ethiopia, Vietnam, Korea, Ireland (457 men vs 443 women) (N= 176 Iranians)	Center for Epidemiologic Studies Depression Scale (CES-D) 10-item expanded version of the everyday discrimination Scale Socio-demographic questionnaire	Compared to other ethnic groups, Iranian immigrants showed higher depressive symptoms in perception of discrimination	Quantitative	High
Jannati and Allen (2018) **The United States**	To explore the relationship between Iranian immigrant parents' acculturation and the level of conflict they experience with their U.S.-born children	N = 100 first-generation Iranian immigrant parents	20-item Conflict Behavior Questionnaire, 4-item Accculturation Conflict Scale, 33-item Bicultural Involvement Questionnaire (BIQ)	Higher parent-child conflict levels amongst families with lower levels of acculturation and lower income. Need for support from schools, counsellors, and relevant institutions for increasing parents and children acculturation.	Quantitative	High

Author	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Ghaffarian (1987) **The United States**	To examine the rate of Iranian immigrants acculturation to American culture, and specifically, the acculturative differences between males and females	N = 110 Iranians	Demographic Questionnaire Warheit and Buhl's Anxiety scale Traditional family ideology designed by Levinson and Huffman (1955) Acculturation scale designed by Cuellar, Harris, and Jasso (1980)	- Less adjustment to host culture = higher stress and depression - Men are more able to adjust themselves with new societies and cultures	Quantitative	High
Ghaffarian (1998) **The United States**	To explore the relationship of acculturation and mental health	N = 238 Iranians	Demographic Questions, Warheit & Buhl's Anxiety, Depression and psychological dysfunction scale Iranian version of Mendoza's Cultural Lifestyle Inventory	- Acculturation increased = score of mental health problems decreased (better) - Men are healthier than women mentally	Quantitative	High
Jafari et al. (2010) **Canada**	To examine the impact of immigration on mental health	N = 44 Iranians	In-depth face-to-face interviews One focus group	- Low English proficiency resulted in social isolation, anxiety, mental problems, joblessness and unstable and aggressive behaviours	Qualitative	High

Author	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Dastjerdi (2012) Canada	To identify the obstacles and issues that Iranian immigrants face to access to health care services through the lens of Iranian healthcare providers	N = 50 Iranian immigrants who work as health providers	in-depth semi-structured individual interviews Narrative inquiry Three focus groups	- Language barrier and lack of knowledge of Canadian healthcare systems - Lack of trust in Canadian healthcare services due to financial limitations and fear of disclosure	Qualitative	High
Dastjerdi (2012) Canada	To explore the process of access to health care services	N = 17 Iranians	Individual face-to-face interviews with a broad question then focused on health-related experiences Story telling	- Getting isolated as a result of poor English skill - Tackling obstacles and being integrated	Qualitative	High
Dossa (2002) Canada	To explore the pedagogical potential of stories of post revolution of Iranian women living in Canada	N = 40 Iranian women	Semi-structured interview Two focus groups Story telling	- Language barriers can result in unemployment or underemployment - Iranians experience depression - Iranians experience discrimination	Qualitative	Medium
Tyndale et al. (2007) Canada	To explore the needs and experiences of Iranian immigrants about sexual health	N = 20 Iranians	Semi-structured interview	- Difficulty in adjusting with new culture where sexuality is not seen as a strange issue - Difficulties in receiving sexual healthcare because of misunderstanding (cultural diversity) and shame and modesty	Qualitative	High
Saechao et al. (2012) The United States	To examine stressors and barriers to using mental health services amongst first-generation immigrants	N = 30 from Cambodia, Iran, Iraq, Vietnam, Africa, Eastern European (N = 4 Iranians)	Six focus groups	- Barriers: Language, cost, lack of information about mental health services - Stressors: discrimination, economic status, difficulty to find suitable job	Qualitative	High

Author	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Meleis et al. (1992) **The United States**	To investigate the nature of the relationship between demographic characteristics, ethnicity, length of time in the USA and physical and mental health/illness status, psychological wellbeing, and perceived health	N = 88 Egyptian, Yemeni, Iranian, Armenian, and Arab immigrant (N = 16 Iranians)	Socio-demographic questionnaire Ethnic identity questionnaire 10-point rating scale Cornell Medical Index Revised Bradburn Morale Scale 10-point Cantril ladder scale	- Unavailability of an ethnic community in overseas can result in depression and isolation amongst elderlies	Quantitative	High
Lipson (1992) **The United States**	To examine the immigration experiences of a sample of Iranians in the USA	N = 35 Iranians	Semi-structured interview Health opinion survey	- Lack of social support - Communication problems because of language insufficiency - Culture shock - Difficulty to find a good job - Financial problems - Ethnic bias (discrimination)	Mixed (Qualitative and Quantitative)	Medium
Martin (2012) **The United States**	To explore elderlies' experience of discrimination in the American healthcare system	N = 15 Iranians	In-depth interview (in person) Open-ended questions	- There was no discrimination - Highly positive impression of American healthcare providers - Language barrier as a factor for underestimating possible discrimination	Qualitative	High
Guruge (2012) **Canada**	To examine the relationship of violence and physical and mental health	N = 30 Iranian women	Harvard trauma Questionnaire Brief symptom Inventory	- About one-third of Iranian immigrant women suffer from mental illness due to intimate partner violence	Quantitative	High

Author	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Khatibsemnani (2014) Canada	To examine the impact of immigration on their health and wellbeing	N = 12 Iranian immigrant women	Semi-structured and in-depth interviews	Poor language proficiency results in delay in seeking healthcare services, social isolation and mental health issue Inability to afford for language classes expenses, work limitations, and limited scheduled classes as barriers to learn English by the Iranian immigrants in Canada Employment affects mental wellbeing; a link between employment and social support and belonging to the host society Employment affects identity formation Lack of an Iranian community leads to lack of social support Discrimination due to "Middle-Eastern" look, including name, accent, national origin, and dressing Utilising healthcare services is affected by expenses the services, long waiting lists, lack of same-sex health providers, and lack of control in referral process	Qualitative	High
Singhammer (2011) Denmark	To explore the relationship of violence and mental health amongst Iranian immigrants	N = 991 Iranian women	A questionnaire including health indicators, health risk factors, healthy behaviours & health care services	- Iranian women had the greatest rate of divorce amongst other ethnic minorities in Denmark - The rate of violence was reported higher amongst Iranian women than other minorities	Quantitative	High
Momeni et al. (2011) Sweden	To investigate the self-reported mental health amongst two Iranian groups, in Sweden and Iran	N = 208 Iranians	An author-made questionnaire	- 21 % of elder Iranian immigrants suffer from depression same as their counterparts in Iran - Depression rate was higher amongst Iranian women compared to men	Quantitative	High

Author	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Moztarzadeh and O'Rourke (2015) Canada	To identify links between acculturation and the mental health of older Iranian immigrants living in Canada	N = 103 Iranians Age > 50	Satisfaction With Life Scale (SWLS) Iranian Acculturation Scale (IAS) Center for Epidemiological Studies-Depression (CES-D)	Life satisfaction and (the absence of) depressive symptoms as independent predictors of acculturation. No direct link between depression symptoms and acculturation. Refugees reported higher levels of depression Loss of occupational status is associated with reduced life satisfaction, but no direct link with depression. low level of discrimination reported	Quantitative	Medium
Tinghög et al. (2010) Sweden	To investigate the association of immigrant and non-immigrant-specific factors with mental illness within a diverse immigrant population	N = 720 from Iran, Iraq and Finland (N = 250 Iranians)	The Hopkins symptom checklist-25 The World Health Organisation Wellbeing Index	- 48 % of Iranian immigrants suffer from depression - 19 % of Iranian immigrants suffer from perception of discrimination - Unemployment and poor social network can lead to depression - Being female is a risk factor for mental disorders	Quantitative	High
Wiking (2004) Sweden	To analyse the association between ethnicity and poor health	N = 2160 From Poland, Iran and Turkey (N = 480 Iranians)	Standardised & translated questionnaire for assessing the socio-economic status	- Discrimination and acculturation are two important mediators between ethnicity and health. - High discrimination is felt by 34 % and 51 %, respectively, by men and women - 41 % of women reported poor health status	Quantitative	Medium
Lipsicas et al. (2012) European countries	To compare the frequency of attempted suicide amongst immigrants and their hosts, and between different immigrant groups	N = 4160 immigrants from various countries including Iran	Data were obtained from the World Health Organisation/EURO Multi-centre Study on Suicidal Behaviour	- Iranians displayed high suicide attempt rate in European countries despite low suicide rates in Iran - Immigration process in itself and the difficulties in acculturation can result in high suicide attempt rates	Quantitative	High

Author	Aim of study	Sampling	Instruments	Main results	Type of study	Quality
Haasen et al. (2008) **Germany**	To find evidence for a relationship between acculturation stress and mental health problems, mainly depressive symptomatology	N = 100 Iranians	Acculturation-stress-index SCL-90-R Hamilton Depression scale	- 28 % of Iranian immigrants suffer from mental disorders without treatment - Depression score was high amongst Iranian immigrant - Inaccessibility of mental care centres	Quantitative	Low
Gerristen et al. (2006) **Netherlands**	To estimate the prevalence rates of physical and mental Health	N = 410 Iranians, Afghan and Somali (N = 117 Iranians)	Medical outcome study SF-36 Harvard trauma questionnaire HSCL-25	- 43.4 % of Iranian asylum seekers suffer from depression and anxiety - Iranians suffer from dental and eye problems, back pain, neck/shoulder complaints, headache	Quantitative	High
Bayard (2001) **Sweden**	To examine the association between ethnicity amongst migrants born in Iran and psychiatric illness and intake of psychotropic drugs	N = 1980 Iranian, Kurd, Turkish, Polish, Chilean (N = 293 Iranians)	Swedish Survey including living condition questionnaire and immigrant specific questions Face-to-face interview	- Iranians a higher risk of mental illness and intake drugs 6 and 5 times more than Swedes respectively. - Feeling discrimination by Iranians was higher than other ethnic minorities	Mixed (Qualitative and Quantitative)	High

Chapter 3: Theoretical framework

3.1 Introduction

Migrants, in particular forced migrants, experience several losses and threatening events prior to their actual migration, during the migration journey, and during resettlement in their host country. Historically, most studies on forced migrants have focused on understanding the prevalence and treatment of mental health disorders of this population. It is only recently that attention has been directed to understanding the demanding process of migration that affects their adaptation, integration, and wellbeing.[288] The Resource-Based Model (RBM) provides an insight regarding experiences over forced migration and their impact on refugees' adaptation and wellbeing in the context of pre-migration, transit, and post-migration periods.[289] This chapter describes the RBM that serves as the theoretical framework for this thesis.

Ryan et al. (2008) introduced the RBM by incorporating three theoretical frameworks including Lazarus and Folkman's transactional model of stress and coping (1984), Berry's acculturation framework (1997), and Hobfoll's conservation of resources theory (1989). Ryan and colleagues believe that the RBM is able to better explain stressors and adaptation in the refugee context than each individual framework alone.[289] Incorporating the three theories and frameworks facilitated the RBM as a testable and practical model that considers psychological wellbeing as a multidimensional issue interrelated with migration and adaptation in the refugee context. The RBM describes the role of individuals, the environment, and resource retainment in adaptation and stress reduction of forced migrants. The following sections provide insight into developing the RBM and the decision to apply it to the current study.

3.2 Lazarus and Folkman's transactional model of stress and coping

Lazarus and Folkman's (1984) transactional model of stress and coping examines the impact of stress on individuals who are in a stressful environment. The model examines the individual's perception of stressors, appraisal process, and coping strategies that are used to reduce stress.[290] This individual-level model emphasises the role of individuals in the perception of stressors and the importance of effective coping skills people must be taught to enable them to overcome stressful encounters.[290] This model fails to consider the environmental factors, such as gender, socio-economic status, ethnicity, and legal status, that affect an individual's perception of stressful encounters.[289] There are some critiques of this model. First, differences in the resources available to individuals in different societies should be considered when their abilities to manage stressors are assessed. Second, stressful encounters do not necessarily happen by chance. For instance, individuals with black skin may be subjected to more stressful encounters than those with white skin in some societies. Therefore, social environments may influence the extent and nature of stressors that individuals face.[289] Accordingly, it is suggested that to understand the adverse impact of environmental stressors, other factors besides an individual's capacity to overcome stressors should be considered.

3.3 Berry's acculturation framework

Berry's acculturation framework focuses on people who immigrate and settle in a new culture different from their own culture.[3] The framework presents 'cultural maintenance' that describes the role of cross-cultural transition in immigrants feeling integrated and less stressed. It refers to the extent to which immigrants believe that their own cultural identity is important, and the extent to which they assimilate to the host society's culture through contact and engagement.[3] Berry's acculturation framework is based on four

concepts –assimilation, integration, separation, and marginalisation. These key factors were explained in Section 1.2. In brief, assimilation allows for attachment to the host culture while refusing one's own culture, integration refers to becoming involved in the host society's culture while keeping one's original culture, separation occurs when a person commits to their own culture with little or no contact with the host culture, and marginalisation is the result of disconnection from both original and host cultures.[3] Amongst the four possible cross-cultural transitions, based on previous research, integration has the best outcome for immigrants as it enables them to participate fully in social, cultural, economic, and political activities in host societies, without an obligation to renounce their own culture and identity.[3,291,292] Moreover, it is believed that societies that accept cultural pluralism are likely to support the continuation of cultural diversity, which links to integration strategy.[3,292]

Overall, Berry's acculturation framework depicts the relationship between cross-cultural contacts and experience of stress by immigrants. However, it seems to exaggerate this relationship and presents an over-culturalised view of the adaptation process for immigrants. As a result, the framework overlooks stressful issues of relocation that are not linked to culture, such as housing, employment, and using healthcare services.[289] Moreover, Lazarus (1997) asserts that the relocation process can impose major stressful demands on immigrants, and views acculturative demands as a subset of a wider category of demands related to migration and relocation processes.[293] He explains that immigrants in a society with a similar culture or in accommodation centres with no contact with a general population of host countries still encounter stressful demands, such as separation from their families, loss of their social position, insecure residency status, housing issues, unemployment, and lack of a meaningful life. In other words, the term 'acculturative

stress' in Berry's (1997) acculturation framework does not appreciate other demands that affect the psychological status of immigrants irrespective of their cultural background.[289,293]

3.4 Hobfoll's theory: Conservation of resources

Hobfoll's conservation of resources theory (1989) revolves around the role of resources in an individual's psychological wellbeing. Resources are introduced in Hobfoll's theory as the "things people value, or that aid in obtaining which is valued".[294] Hobfoll describes the loss of resources during the migration process as a major stress for migrants. Being threatened with potential or actual loss of resources, and lack of success in their attempts to regain the lost resources imposes significant psychological stress.[229] This theory demonstrates that loss of a certain resource would have a similar impact on different individuals in similar circumstances. This means that the theory places greater emphasis on resources when examining an individual's psychological wellbeing.[289]

Ryan et al. (2008) criticise this theory. First, the theory over-emphasises the role of resources in a stress model through considering resources as goals without any distinction between resources and goals. This view disregards the possibility that resources such as money and education may be used differently by diverse groups or individuals. Second, stress is defined as the loss of resources without any room for other stressors, such as experiencing or witnessing loss of safety or racism.[289,290]

3.5 The resource-based model: A model of refugees' adaptation and wellbeing

The process of migration, particularly when it is forced, is stressful, complex, and multidimensional. The aforementioned theories each revolve around one dimension of

migration that influences an individual's adaptation and effort to reduce their stress; the role of the individual in Lazarus and Folkman's transactional model of stress and coping, culture in Berry's acculturation framework, and resources in Hobfoll's conservation of resources theory.

Alternatively, the RBM considers the various dimensions when discussing adaptation and the psychological wellbeing of forced migrants. Migrant adaptation refers to the ability of migrants to rebuild or reorganise their lives in a new socio-cultural society. There are a variety of theoretical underpinnings towards successful adaptation of immigrants facing a new environment. For example, socio-cultural models believe that successful adaptation occurs through effective interaction in a new cultural environment.[295] While economic models suggest that access to the labour market and regaining pre-migration employment status helps immigrants successfully adapt to their new environment,[296] the RBM provides a multidimensional insight towards adaptation by considering a range of resources that empower forced migrants to adapt to the new environment and maintain their psychological wellbeing.[289] It also asserts that resources should meet each individual's specific needs, goals, and demands through different phases of migration. As a model of refugee adaptation and wellbeing, the RBM considers individuals' lives before migration, such as their experience of threat and trauma; during transit, such as experience of fear and uncertainty; and post-migration, such as facing a range of resettlement difficulties and socio-cultural differences.[289] The RBM describes migrant adaptation as a process through which individuals try to survive through meeting their needs, pursuing their goals, and investing in management of the demands they encounter during migration and settling into a new society. Contrary to cross-cultural adaptation, migrant adaptation

encompasses a range of demands migrants encounter during relocation, not only those rooted in culture.[289]

The RBM defines resources as "the means by which individuals satisfy needs, pursue goals and manage demands".[297] The RBM allocates key resources into four main categories: personal, material, social, and cultural. Personal resources encompass an immigrant's physical and psychological resources. Physical resources include an individual's appearance, physical attractiveness, health, and energy level. Psychological resources include skill-based resources, such as problem-solving ability, and trait-based resources, such as self-efficacy, self-esteem, hope, and optimism.[289] Material resources include all monetary assets that individuals may lose or gain during migration, such as a home, money, income, car, and leisure activities. Social resources point to personal relationships that can help immigrants to experience a smoother adaptation to the new society. These include emotional and informational supports that immigrants receive from a social network to give them a sense of belonging and identity in the new society.[289] The RBM also considers cultural resources that facilitate adaptation of refugees into the new environment. These resources include beliefs, skills, and knowledge of individuals such as language competency and computer skills, literacy, and education. Religious or philosophical beliefs that bring a sense of meaning to individuals' lives, as well as awareness of available services, such as healthcare services or public transport, are also categorised as cultural resources in the RBM.[289]

Despite the distinction between the four groups of resources, a significant interrelationship exists between them. Lack of legal residency status as a social resource, for example, may lead to restriction on enrolling in a language course, which can result in fewer opportunities for forced immigrants to improve their language skills as a cultural

resource. Lack of English language proficiency may hinder individuals from obtaining secure employment and income (material resources) and increase the risk of emotional and psychological problems, lower self-esteem and hope for the future as personal resources.[298,299]

Resources can be lost, decreased, gained or increased. Ryan et al. (2008) propose two dimensions of change in resources. First, the extent of resources may change during the migration process. Loss of resources refers to a decrease in the amount of a resource, such as social support, or outright loss of a resource, such as employment. Gaining resources refers to the acquisition of new resources, such as language skills, or an increase in the extent of resources immigrants already have, such as a higher income. Second, the extent of a resource may remain constant, but its value may change in relation to the satisfaction of needs, goals, and management of demands in different host societies.[289] For example, proficiency in the French language may be marketable in European countries while the same skill may have little benefit to a person living in Australia.

In addition to changes in resources, the RBM emphasises duration of the change as affecting forced migrants' mental health. For example, while a lack of sufficient food supplies threatens individuals' wellbeing, length of exposure to hunger is also important. Likewise, duration of trauma is an important consideration when forced migrants' wellbeing is studied. For example, permanent losses, such as destruction of family or death of a family member, predict greater negative impacts than temporary losses that are recoverable over time.[289]

The model asserts that certain migrant populations are more likely to have fewer resources compared to other groups. Ryan et al. (2008) believe that refugees, especially those who fled war and torture, are under-resourced migrants. They integrated the theory of the

resource loss spiral, previously suggested by Hobfoll (2001), into the RBM. The resource loss spiral theory posits that the loss of primitive resources may undermine one's ability to gain other resources leading to further losses.[300] For example, immigrants whose qualifications were devalued in the host country may face fewer employment opportunities. These people often have lower ability to gain new resources. Accordingly, people with fewer resources upon arrival in a new environment are at greater risk of experiencing poor adaptation and psychological problems.[289]

The RBM suggests strategies to compensate for the losses and ease immigrants' adaptation to new environments. Resource replacement and resource substitution are two main strategies considered in this model.[289] In resource replacement, people replace lost resources that are not expected to be gained in the near future. For example, they replace family support with support from friends and religious communities. In resource substitution, individuals try to compensate for a lost role with investment in another role. For example, a man who lost his role as breadwinner for his family may compensate by accepting the role of caregiver to his children.[289] The RBM considers replacement and substitution of resources as effective strategies to help forced migrants cope with migration-related demands and losses; however, further coping strategies can be employed.

In general, four central issues emerge from the RBM. First, the RBM asserts that an individual's needs, goals, and demands determine the resources forced migrants require to experience less stress and more adaptation into a new environment. Second, pre-migration, transit, and post-migration experiences should be considered when the aim is to understand the adaptation and psychological wellbeing of forced migrants. Third, rules and policies of a host country regarding forced immigrants, such as work and study

restrictions may prevent immigrants from accessing and using key resources. Finally, due to the dynamic nature of migration, required resources to maintain wellbeing are constantly changing.[289]

Although the RBM has received limited evaluation in health research, it was deemed relevant to the current study because of its focus on experiences of forced migrants during the three phases of migration and it prioritised migrant adaptation over cross-cultural adaptation because the former encompasses a broad range of demands forced migrants encounter over migration.[289] Moreover, applicability of the four key issues to the current study guided the development of the research questions and provided insight into understanding the participants' experiences and discussion of the study findings.

Chapter 4 : Methodology and methods

4.1 Introduction

Chapters 1 and 2 established the need to explore Iranian asylum seeker women's experiences of migration and resettlement in Australia and their health needs. Chapter 3 provided the theoretical underpinnings towards forced migration through which individuals carry specific needs and goals, and endure demands that determine the importance of various resources in newcomers adapting to a new environment and their psychological wellbeing.

This chapter describes the research paradigm guiding the development of the study and the rationale for using a qualitative approach to data collection and analysis. This chapter also describes and justifies the method of the study, including sampling, participant recruitment, and collecting and analysis of data. In addition, this chapter outlines the strategies that were used to enhance the rigour and strength of the study and ethical considerations.

The aim of this study was to explore Iranian asylum seeker women's experiences of migration and settlement in Australia and the impact of these experiences on their health and wellbeing. To conduct this study, a qualitative approach was deemed most appropriate to gain an in-depth understanding of the participants' experiences and to facilitate the voices of the people whose accounts tend to be discounted and marginalised in the literature.[301] Qualitative research is appropriate for studies exploring social relationships, due to diversity in individual ways of living and biographical patterns in postmodern societies.[302] For this reason, social scientists argue that narratives are required to address the issues.[302]

As a result of rapid social changes and a diversity of lifestyles, social researchers are increasingly confronted with new social perspectives and contexts. Due to the differentiation of social perspectives and contexts, social researchers found it illogical to apply traditional deductive methodologies in which they design research questions and hypotheses according to predetermined theoretical models and test the models against empirical evidence. Thus, inductive strategies became increasingly used in social research.[302] In other words, in a social study, open questions are asked about a phenomenon that occurs instead of testing predetermined theories and hypotheses. Yet, emergent concepts can be influenced by the researcher's previous theoretical knowledge.[302] Since the aim of this study was to explore individuals' actual experiences of their lives during migration and resettlement and their perception of their health status, an examination of narratives[303,304] was required.

4.2 Research design

4.2.1 Epistemology

Epistemology is described as "the study of the nature of knowledge and justification" and answers the question of "how do we know what we know?".[305] Crotty (1998) states that epistemology is a way of explaining and understanding knowledge that informs methodology and the method of research.[306] In Crotty's epistemological view, there are three positions – objectivism, subjectivism, and constructionism.[306] In constructionism, which informs the epistemology of this qualitative study, the meanings are constructed through interaction between the researcher and participants, and the meanings may be constructed differently by different people even regarding the same issue.[306]

Crotty states:

> *Meaning is not discovered, but constructed. In this understanding of knowledge, it is clear that different people may construct meaning in different ways, even in relation to the same phenomenon. Isn't this precisely what we find when we move from one era to another, or from one culture to another? In this view of things, subject and object emerge as partners in the generation of meaning.*[307]

According to Crotty, constructionism focuses on individuals as the units of constructing meanings of experiences and their reaction to a specific experience. The constructed meanings can shape the way through which individuals see things and define their social context.[306,308] Research that is guided by constructionism sees the world as constructed, interpreted and experienced by individuals in their personal interactions with other people, life realities, and within social contexts they live in.[309,310] A constructionist researcher challenges the belief that human knowledge and objective truth are not waiting to be discovered, but individuals construct their own interpretations in different ways, even regarding the same phenomenon. This means that constructionists invent models, concepts, and schemes to make sense of an experience, then continually test and modify them through interpreting and constructing meanings from new experiences.[303]

In the context of this study, the researcher believed that individuals with different personal and socio-cultural characteristics construct different meanings for what they perceive during migration and settlement in Australia, as a new society and in a socio-culturally different context. According to Bruner (1991), the societies individuals live in determine how they perceive or construct meanings. Although meanings are constructed individually, they originate from a social context.[303] Considering the aim of the current study, constructionism was applied to support understanding of the participants' experiences of migration and settlement in a new social context in Australia; opening up

meanings and perspectives to be explored through direct interaction between the researcher and the participants.

4.2.2 Theoretical perspective

A theoretical perspective is a set of assumptions about a phenomenon that informs the series of questions asked and the answers the researchers reach as a result. A theoretical perspective provides a lens through which the researcher looks, focuses, and understands certain things. A theoretical perspective is important in qualitative research because it organises and clarifies the researcher's thoughts and ideas.[311] Crotty (1998) states that the theoretical perspective adopted by a researcher is related to their epistemology, the methodology, and the method used to conduct a research study.[306]

The epistemological basis and theoretical perspective used in this study are consistent with constructionism and interpretivism. Interpretivism is a perspective that emphasises mutual interaction between participants and the researchers as the basis for the construction of knowledge. Interpretivists use their skills to understand how research participants perceive their world. Thus, the knowledge will be constructed by the mutual interaction and negotiation in a specific situation that is investigated.[312] O'donoghue (2006) recounted Smith and Lovatt's (1991) statement to clarify use of interpretivism through mutual communication:

> *The only way that you can prove to us (or we can know) that you have understood my ideas with the meaning that we intended, is for you to paraphrase in your own words, the meaning that you have gained from my words. In other words, a very important way that we come to know something is through a negotiation of meaning through communication.*[313]

As Smith and Lovat (1991) suggest, emerged meanings often needed to be negotiated between the researcher and the participant to prove the constructed knowledge.[314] Accordingly, in the current study, the researcher facilitated a mutual conversation through which the participants narrated their life stories to provide an in-depth exploration of their perceptions and experiences of migration and their health status. The conversation provided the opportunity for both participants and the researcher to negotiate a specific experience to ensure best meaning constructed. Then, the researcher interpreted the narrations in her own way. Therefore, both participants and the researcher in the current study brought their own personal views to construct a meaning out of an experience. This approach was consistent with interpretivism paradigm.[312] The incorporated conceptual framework and the RBM as the theoretical framework used in this study, helped the researcher to interpret narratives and construct meanings out of the participants' stories and experiences.

4.2.3 Methodology

Methodology is defined as the description, explanation, and justification of methods used in conducting research.[315] The aim of this study was to explore the Iranian asylum seeker women's experiences of migration and settlement in Australia and their health and wellbeing. In alignment with constructionism and interpretivism, a qualitative methodology was employed to explore the participants' experiences and construct meanings out of the experiences and the way the participants reacted to and perceived the reality of their lives in the context of their forced migration.[316] To empower study participants and allow them to open up a conversation about their experiences a narrative approach was required.[317]

Bruner (2004) describes narrative research whereby participants are asked to talk about their experiences and life realities in a way that the interest of the researcher is not the stories so much, but how the narrators construct meaning out of the reality of their lives.[317] In the last decades, narrative has been increasingly paid attention to in social research. In this study, the narrative methodology as a qualitative approach facilitated the researcher and the participants to open up a mutual conversation about migration experiences and the participants' health status to capture rich data through stories.[318] Moreover, the narrative methodology enabled inductive collection of an extensive amount of data with the aim of allowing the data to emerge from a single experience or a series of experiences for a small number of participants.[318-320] Then, the narrative methodology enabled the researcher to reconstruct knowledge from the participants' stories,[321] which is aligned with interpretivism.

4.3 Method

4.3.1 Sampling

A purposive sampling was used to select the participants for this study. This sampling method targets individuals with experience of the topic being studied to enable in-depth exploration.[322,323] Participants were purposively sampled if they were women who came to Australia by boat, were aged 18 and over, spoke Farsi/Persian, were born in Iran, had asylum seeker status, and had lived in Australia for between two and three years.

Only women aged 18 years and older were eligible for inclusion in this study. The Australian Government (2012) reported that 81% of boat arrivals to Australia were 18 years and over.[324] Participants were sampled only from the Sydney area as settlement experiences can be differentially affected by living in various social and cultural contexts

in Australia.[325] The amount of time of settlement in Australia was selected as between two and three years after arrival in Australia because research shows that a major part of adjustment is completed after this amount of time living in a host country.[326-328]

4.3.2 Recruitment

Refugees and asylum seekers are generally considered to be a hard-to-reach and hidden population in health research.[329] Health researchers experience significant challenges around recruitment of this population, particularly if individuals had experienced torture, persecution, and trauma before migration and during the journey to host countries. Those whose refugee status is still undetermined may also have concerns about stigma and their privacy being violated by participating in research.[330,331]

The target participants of this study were Iranian women whose refugee applications were still under review. Not having secure residency status could hamper the willingness of potential participants to freely share their personal information and experiences with a researcher with whom they had no prior relationship.[332] To surmount this barrier and access the community, the researcher became involved in the community to which these women belonged. This allowed her to become familiar with members of the community and overcome the communication barriers for recruitment and data collection.[333]

Despite sharing the same language and cultural background with the community, the researcher felt the need for a gatekeeper to broker engagement with the community. She met an Iranian asylum seeker woman informally at a social event. The woman had come to Australia by boat in 2013 and her refugee application was still undetermined when she met the researcher in mid-2013. Upon realisation that the researcher was also Iranian, the woman asked her to act as an interpreter for her so that she could communicate with non-

Farsi speaking people at the event. In turn, the researcher sought the woman's advice about accessing Iranian asylum seeker women for the purpose of her study. Appreciating the potential value of the research for the Iranian community, the woman invited the researcher to attend a community organisation where she was introduced to others. The woman was a well-respected community member and her brokerage facilitated the researcher's engagement with the community. This engagement helped the researcher build rapport and trust with community members, which facilitated participant recruitment.[333]

This community was being supported by a multicultural community centre in Western Sydney, a non-profit organisation that offered a variety of services including educational, social, and recreational activities to asylum seekers. Western Sydney is a region of diversity and extends from Auburn and Bankstown to the Blue Mountains. The region is the most diverse area of Sydney, with 38% being non-English speaking. The Iranian population is one of the largest and fastest-growing populations in this region.[334] As part of the community program, Iranian asylum seekers attended weekend events at this community centre in Western Sydney. First, the woman the researcher had met casually at the social event introduced the researcher to the community leader who was working voluntarily in the multicultural community centre. The community leader was a community elder who had a passion to voluntarily assist new arrivals from Iran, in particular asylum seekers, to settle in the new society. Her respected position in the community was also important for the researcher to be accepted by the community members. An informal conversation with the community leader facilitated a better mutual understanding of the community's scope, its members, and the research aim. The researcher then requested the multicultural community centre for permission to recruit

participants from the community for the purpose of the study. After obtaining formal written approval from the multicultural community centre (Appendix 7), the researcher attended the weekly events to build and develop rapport with the women in the community. As a qualitative researcher seeking an in-depth understanding of individuals' life stories and experiences, constructing a mutually meaningful and trustful relationship with the potential participants was critical.[335]

Building rapport and a trusting relationship with potential participants was important to increase the chance of obtaining rich descriptions of the participants' experiences.[336] As a result of a variety of negative experiences before, during, and post-migration, and not being certain about their residency status and future in Australia, it was expected that the target population might be reluctant to share their personal information and experiences with the researcher.

Sharing the nationality, language, and culture considerably lifted interaction barriers;[337] however, having arrived in Australia on a student visa (as opposed to illegally by boat) placed the researcher in a higher social position and power compared to the asylum seeker women. In contrast to most of the asylum seeker women, the researcher had legal permission to study and work in Australia. She also had permission to travel to Iran to visit her family and return to Australia, which the asylum seekers were not able to do. This provides evidence that the researchers' position, power, and privilege may complicate the relationship with a specific population and community when conducting community-based participatory research.[338] The higher social position of this researcher hampered a mutual interaction with community members during the first weeks of attending the community's weekly activities. The poor interaction could affect her ability to convey her honesty and empathy to the community members. However, the ongoing

support of the community leader, who acted as the gatekeeper, facilitated the first tier of communication with the community members. Prolonged engagement with the community members through attending weekly events for a period of six months enabled the researcher to establish trusting relationships with the women. In the weekly gatherings, the researcher assisted the community members with any issue that required English language proficiency, such as housing paperwork, assistance with submitting bill payments, and searching for jobs on the internet. When appropriate, the researcher shared her intention of conducting the research to estimate the women's interest in participating in the study.

In addition, to build mutual interaction, the researcher answered questions raised by community members about her background and her current life. The most frequent questions were about her professional background, current residency status, and employment in Australia. In response, the researcher introduced herself as a PhD student at the University of Technology Sydney, living in Australia as a new immigrant with a midwifery background from Iran. Sharing the personal information with the women demonstrated her honesty and openness and made the women feel comfortable to participate in the study and invite the researcher into their homes for interviews.

While the community leader was essential in introducing the researcher and establishing her credibility that helped with participant recruitment at the beginning, application of the above strategies enabled the researcher to gradually engage with potential participants and recruit on her own after this introductory period.

The researcher began with location sampling to select the participants for the study. Location sampling is used when a rare population can be identified by its activities. In this type of sampling, researchers visit places that the population usually gather to recruit

participants.[339] When the researcher ensured that an adequate number of the women were willing to participate in the study, she distributed the study information sheets and invitation letters in Farsi/Persian and English (Appendices 8-11) along with providing oral information in Farsi/Persian about the study. The information consisted of details about the study aims, expectations, potential benefits and risks for participants, and contact details of the researcher and supervisors. Those who expressed their willingness to participate in the study in person or via phone were provided with further details about the study aims and expectations as per their requests.

Snowball sampling was also used whereby the researcher asked a participant to introduce other participants who met the eligibility criteria and may be willing to participate. Marcus et al. (2017) present snowball sampling as a pragmatic and cost-effective method of sampling that facilitates the researcher in accessing hard-to-reach informants from a wider community.[340] In addition, snowball sampling is particularly applicable in studies that focus on sensitive matters including beliefs, attitudes, and lived experiences. It allows the recruitment of individuals who may otherwise be hesitant to participate in these types of studies.[341,342]

In the current study, previously recruited participants first sought verbal permission from the nominated persons for giving their contact details to the researcher. The researcher received the contact details of those who were interested in participation, she then contacted them via phone and explained the research aims, expectations, and potential benefits and risks for participants. The researcher also explained the steps she would take to ensure the confidentiality of the participants. Those who desired to participate in the study sent their residential address and a preferred interview time to the researcher through a text message. The researcher provided these participants with the information

sheet and invitation letter on the scheduled day for the interview. Overall, 12 participants were recruited through snowball sampling and five participants through the location sampling.

4.3.3 Data collection

Data were collected through semi-structured in-depth interviews and a rough interview guide was developed and used to guide the interviews.

4.3.3.1 Interview guide

The researcher used an interview guide to conduct semi-structured interviews to explore participants' understandings, perceptions, and experiences of migration and settlement in Australia and their health outcomes. An interview guide is a practical way to help the researcher make the best use of time during interviews and refine interview questions where applicable.[343,344] It also assists researchers to steer and guide the interviews. With this in mind, the semi-structured interviews were guided by the interview guide to ensure all topics were adequately covered and the research questions addressed.[343,344]

The interview guide used in the current study was developed in two stages. In the first stage the researcher reviewed the findings of the literature review on the impact of immigration on Iranian immigrants' health status. The framework, which was developed through analysis of the experiences of Iranian immigrants, enabled the researcher to develop an understanding of different aspects of the lives of this population group who are affected by immigration.[112] The results of the review of the literature on refugee and asylum seeker women's socio-cultural and health needs also provided insights about common lived experiences of this population worldwide, particularly around gender-based experiences.[345] The findings of the two literature reviews, detailed in Chapter 2,

provided the researcher with a perspective about Iranian refugee and asylum seeker women's experiences of living in a diverse socio-cultural contexts and their health outcomes.

In the second stage, the review of the RBM that informed this study's theoretical framework provided an insight regarding forced migrants' experiences of migration and resettlement in host countries and resulting mental health problems. The information raised from the literature reviews and a careful review of the RBM as well as feedback from the study supervisors contributed to the interview guide development.

Research objectives were considered as overarching concepts to structure the questions of the interview guide. Open-ended questions were designed to allow for exploration of new concepts and to elicit in-depth data about experiences of participants through all phases of migration from pre-migration, transit, to post-migration. The questions were also designed in a way to allow the participants share their health status and the strategies they developed to maintain their wellbeing. The questions followed a chronological sequence and began from pre-migration experiences and ended with resettlement experiences in Australia (Appendix 12). The interview guide was revised following preliminary analysis, and the order of the questions changed from one participant to another to maintain the flow of the interviews.[346]

4.3.3.2 Interviews

Semi-structured in-depth individual interviews were undertaken to explore the participants' understandings, perceptions, and experiences of migration and settlement in Australia.[347] Semi-structured in-depth interviews facilitated the researcher to vary questions as needed to collect detailed accounts for analysis and ensure the aims of the study were addressed.[348,349]

Data collection occurred from February to November 2015. All interviews were undertaken in the participants' homes, because they perceived that as most convenient. Interview times were also arranged at the preference of participants. The researcher interviewed all participants at their scheduled times except for one who re-scheduled the interview due to her husband's unforeseen early arrival home.

Although the participants had already received the study information sheet and invitation letter, at the beginning of each interview, the researcher introduced herself as a postgraduate research student at the University of Technology Sydney, provided information about the study objectives, and obtained consent from the participant for participation in the study and recording the interview.

After this introduction, the participants were asked to complete a socio-demographic information sheet, which was administered in Farsi/Persian (Appendix 13). King and King et al. (2018) suggest collecting socio-demographic information at the same time as obtaining consent to participate in the study before commencement of the interviews.[350] The socio-demographic information sheet included questions about the participants' age, marital status, number of children, educational status, occupational status in Iran and Australia, financial status in Iran, date of entry to Australia, the detention centre they were held in upon arriving to Australia, length of stay in detention centres, and their religion. One question about post-migration financial status was removed from the socio-demographic information sheet following initial participants' refusal to provide this information. The collected information provided the researcher with a general overview about the participant's personal characteristics that could assist in varying or developing the questions to gain as much information as possible to answer the research questions.

For example, if a participant had children, some questions would be added to explore the participant's experience of parenting in a diverse cultural society.

Following collection of the socio-demographic information and consent to participate, the interviews commenced. Each interview lasted for 1–1.5 hours and was recorded using a digital audio recorder. Recording the interviews allowed the researcher to focus on the participants and maintain the flow of the interviews. All participants gave permission to be audio recorded for the purpose of transcription and analysis. In an effort to allow participants to feel comfortable, the audio recorder was switched on when the researcher began explaining the interview procedure prior to commencement of the interview.[350]

The researcher started interviews by asking the participants to describe their lives in Iran before migrating to Australia. This question was followed by their experiences of travelling to Australia and their stories of living in Australia. As needed, prompts and probes were used to elicit additional information from the participants. The probe questions focused on eliciting more details about the participants' meanings of their experiences.[343,344] In some cases, it was difficult for the researcher to probe for details of a certain experience. For example, all participants stated that they flew from Iran to Indonesia legally with their travel documents (e.g. Iranian passport). For those who stated persecution as the push factor to leave Iran, it did not seem possible to the researcher that the participants could legally cross the borders. Despite her interest in making this subject clear, she did not seek additional information when only general comments were made about sensitive matters. The researcher was aware that probing about these details could upset or distress the participants and hinder the interview process. During interviews, the researcher also took note of body language and other non-verbal cues of the participants as they conveyed insights into how they felt about some issues and experiences. Such

notes included gestures, silence, emotion, and whether participants accentuated a particular word. However, the researcher tried to minimise note-taking so as not to distract and disrupt the flow of the interviews.[351]

To avoid obtaining an unnecessarily large sample and repetitive data, the researcher followed the concept of data saturation as a guiding principle during data collection.[352] Data saturation was achieved when the researcher and the supervisors were assured that no new data and themes were emerging from the interviews.[353,354] Through conducting preliminary analysis and the creation of summary tables for the interviews (detailed in Section 4.3.4.2), the researcher recognised when data saturation occurred.[353] At the point of 15 interviews, no more new concepts and themes were produced. To ensure saturation, however, two more participants were recruited and data collection was stopped with 17 participants.

4.3.3.3 Positioning of the researcher

In qualitative research, the researcher can impact the process of the study from the first stages of data collection to making sense of the collected data and the final presentation of the findings.[355] The researcher's positioning includes personal and socio-cultural characteristics, such as age, gender, race, immigration status, language, beliefs, preferences, political and ideological stances, sexual orientation, and emotional responses to participants.[355] In the current study, the researcher was an Iranian woman who entered Australia under a student visa about six months prior to commencing this research project. Having her academic qualification of midwifery along with eight years of experience of working in women's health in Iran motivated her to undertake a research project on the health of Iranian women living in Australia. The researcher also completed a Masters of Midwifery in Iran, during which she carried out a research project on the relationship

between social support, quality of life, and perceived mental health of Iranian pregnant women. As a new immigrant woman, the researcher had a sense of empathy with Iranian women who were struggling to resettle in Australia. Besides, based on the mentioned academic experiences and knowledge, the researcher saw herself in the position to assist Iranian asylum seeker women as the vulnerable and silent population in Australia to be heard. The knowledge about Iranian women's health and social needs from her previous studies, research, and work experience in conjunction with her advantage of sharing a similar culture and language with the participants placed her in a unique position to conduct the current study.

At the time when she was preparing her PhD research proposal, the topic of illegal boat arrivals and the new immigration policies against these people, such as not allowing them to be settled in Australia or not granting them a PPV, gained great visibility in the media.[12,356] Although the researcher was not previously familiar with illegal maritime entry, the media coverage evoked her curiosity about boat arrivals' living conditions and future in Australia. In addition, hearing the strict policies averting boat arrivals' resettlement triggered the researcher's sympathy and concern towards the living and health condition of her country fellows, who comprised the highest population of boat arrivals at the time the researcher was preparing her PhD proposal.[357]

The researcher's previous experience of research, as part of her Masters of Midwifery study, assisted her in understanding of potential difficulties associated with research on vulnerable women, such as access issues and developing trust with the target population. Her midwifery background also facilitated a sense of rapport and trust with the participants. A midwife is culturally recognised as a professional, friendly, and approachable person in Iran that women can trust and speak to openly. While her

privileged position as a legal immigrant could have potentially hampered participant recruitment, having a midwifery background and familiarity with research on vulnerable populations facilitated participant recruitment and data collection.

Ahren (1999) recounts Colaizzi's (1978) statement, "how could the word hunger ever have conveyed any meaning if we did not once ourselves experience hunger?".[358] Accordingly, being a woman and a mother sharing a similar socio-cultural background, familiarity with current social, political, and economic issues in Iran, and having some common resettlement experiences as a new immigrant in Australia, contributed to the researcher's immersion into the topic and placed her in the role of the 'insider' to some degree. This offered the researcher three advantages: 1) potential access to the target participants, 2) understanding of the social, cultural, and political context, and 3) understanding nuanced responses and reactions of the participants.[355]

In addition, her positioning as a research student independent from the governments of either Iran or Australia engendered confidence in the participants that this was a research study that would not harm them, but rather, could enable their voices to be heard in academic and political fora, with potential to effect change in immigration policies.

4.3.3.4 Reflexive account

Researchers' identities, including their own experiences, perceptions, and emotions, can affect the research process.[355] To surmount this issue, the researcher employed strategies to minimise the risk of bias throughout the research process, from recruitment of participants to data analysis and reporting the study findings. First, during interviews the researcher tried to minimise the expression of her situation and perspectives and instead maximised the space for the participants to speak and share their stories. This also aligns with the ethics of her own need for self-protection. Consequently, she was constantly

conscious about how much, when, and in which manner she should disclose personal information. She made the effort to be open and responsive in sharing aspects of her experiences of resettlement; however, she was careful not to be seen as imposing or intrusive.[355]

The researcher was conscious about her assumptions about the study population and that these assumptions might have affected her interpretation of the experiences of the participants. For example, the portrayal of boat arrivals as illegal immigrants by the media could affect the researcher's interpretation of the difficulties the participants confronted after entry to Australia. To decrease the risk of bias, the researcher strived to leave her pre-existing assumptions aside and immersed herself in the narratives. She consciously applied a continual process of self-appraisal about her position in the research[355] and challenged her attitude and beliefs about boat arrivals and the current immigration policies against this population. Following up the news on recent political and social situations in Iran helped the researcher to eliminate any negative attitudes about Iranian people who came to Australia by boat. Moreover, writing her interpretation and reflections reduced the risk of amalgamating the researcher's experiences and conceptions with what the participants shared.[359]

Third, to protect herself as a researcher from potential risks, such as mental distress due to, for example, heartbreaking stories of separation from children and loved ones, self-care strategies were developed. Conducting qualitative research on an emotionally laden topic can overwhelm the researcher both emotionally and physically.[360] The practical strategies that helped the researcher to maintain her emotional wellbeing over the process of data collection and analysis include the following:

1. Reflexive journal writing: making notes about feelings, biases, thoughts, and historical circumstances in a journal has been suggested by previous qualitative researchers to promote reflective thinking.[360] After each interview, the researcher took notes about the interview process, the setting, the participant's feelings, thoughts, non-verbal behaviours, and any reaction to different parts of the participant's story. The following excerpt is an example of the journal writings:

   Interview with Shiva was a sad one. She was a divorced woman who left her little son in Iran to save her own dignity, future, and mental wellbeing through immigration to Australia as a supportive country for women. She cried frequently in particular when was talking about her son. She tried to keep talking about her son throughout the interview. For example, in response to all questions, even those about her experiences during the transit period in Indonesia, she tried to somehow relate her feelings and perceptions to her son. As an Iranian woman and mother having spent the first 33 years of my life growing up in Iran, I was familiar with the social and cultural context the participant was talking about. Having knowledge about the divorced women's life situation in Iran and the miseries they have to tolerate in being disconnected from their children after divorce enabled me to understand and comprehend her story deeply. So, hearing the story evoked my emotions as I couldn't control my crying during the interview. During the interview I liked to give her a hug to show my emotional support; but, of course, I didn't.

   Writing such notes helped the researcher to look back over them later while reading the transcripts to see the experience as a whole and review the patterns of her emotional reactions. The written reflexive journal also empowered the researcher to identify the external factors, such as the time of the interview that may have affected the collected data, and helped her to develop her interview skills.

2. Peer debriefing: the researcher was aware from the beginning of the research that peer debriefing is a critical process in studying sensitive topics that helps her

manage her emotional reactions.[360,361] Engaging in monthly meetings with the supervisors from the beginning stages of data collection provided the researcher the opportunity to discuss the emotional challenges that she faced during the interviews. In the meetings, the researcher recounted how she was emotionally affected by hearing the participants' life stories. The researcher was fortunate to have supervisors with prior research experience with Middle-Eastern women and in the field of psychology. One of her supervisors was a woman from Iran, so she had a shared understanding of contextual issues and language. The supervisors would listen sympathetically and react in a caring and reassuring way such that she did not feel alone in experiencing emotional stress during the research process. In addition, the supervisors informed the researcher about the counselling services for students at the university which she could use if she was feeling in need of additional support.

3. Maintaining balance: having a social and emotional support network is critically helpful in management of stress associated with conducting qualitative research on sensitive topics.[360,361] During this PhD journey, the researcher was supported emotionally by her husband and son, who taught her that life is more than just study and work. Spending time with them on weekends and public holidays helped the researcher to maintain a balance between the reality of her own life and the transcripts, stories, and the heavy and emotion-laden research content. Attending social events, undertaking exercise, and travel also helped the researcher to achieve a balance between her study and personal life. Moreover, spacing interviews allowed time for the researcher to manage her stress, emotional reactions, and physical symptoms.[360-362] The importance of spacing became apparent to her when conducting two interviews on the same day at the beginning

of data collection that overwhelmed her with emotional stress and caused a severe headache. Following that, she spaced the interviews. Between the interviews the researcher completed transcribing, translating, and preliminary analysis of the last interview.

4.3.3.5 Participants' statement of their participation

The interviews ended with the question about the participants' opinions and feelings about their participation in this study. All participants expressed their satisfaction in participating. Some participants said that this study provided them with the opportunity to talk about the expectations, needs, and difficulties they encountered during migration, particularly during the years of living in Australia. They wished the current study outcomes could help them to overcome their ongoing problems.

> *I am very happy to talk to you. I feel that you will transfer my voice to somewhere. I like my voice to be reached out to relevant authorities to inform them about the difficulties we [asylum seekers] have. (Paria, 40)*

Surprisingly, two participants said that they assumed they were talking to a psychological counsellor while they were speaking about their experiences and expressing their feelings. This ensured the researcher that the study process did not cause harm to the participants.

> *They [negative experiences] will become indelible if you forget them. If you bury them inside yourself, they will turn into [physical] sickness … You [the researcher] are like a psychologist. It is a long time I haven't met my psychologist. This interview allowed me to talk and now I feel happy. (Nasrin, 35)*

4.3.4 Data analysis

Qualitative data analysis involves making sense out of interviews, moving deeper into understanding the data, and interpreting the meaning of the data.[319] Narrative inquiry has been described as both a methodology and a way of understanding an experience when analysing narratives.[321] Consistent with social constructionism and interpretivism, a thematic analysis was undertaken to construct a comprehensive meaning of participants' life stories and experiences of migration, settlement in Australia, and health outcomes.[321]

Thematic analysis was undertaken to encode qualitative accounts to create themes and sub-themes as the patterns of meaning to describe and interpret aspects of a phenomenon or experience.[363] Thematic analysis allowed the researcher to make sense of unique and collective experiences across the qualitative data set. In this study, the researcher followed the steps of a thematic analysis to thematically analyse, interpret, and construct meanings out of the participants' collective and unique experiences and life stories.

The data analysis was undertaken through employing an inductive approach. Inductive analysis is applied when a researcher develops concepts and themes from raw data rather than being influenced by previous theoretically-derived concepts.[364] The purpose of this approach is to empower the researcher to identify findings from the frequent, significant, or dominant accounts in raw data to generate first-hand and relevant findings to the research aims. Research aims provided a focus on analysis of raw data instead of having priori assumptions and expectations about the participants' lives and experiences. In this study, the inductive approach facilitated the researcher to describe the actual perceptions of the participants about their experiences of migration without being influenced by pre-existent knowledge.[364]

4.3.4.1 Thematic analysis

In alignment with social constructionism and interpretivism, a thematic analysis was undertaken to construct meanings and knowledge out of the narratives.[365] The analysis process was undertaken through following six steps. First, the analysis began with the researcher carefully listening to and transcribing verbatim the audio recordings immediately after each interview in Farsi/Persian. The researcher integrated any handwritten notes into the transcripts and de-identified the materials by replacing participants' actual names with pseudonyms. Each interview took about six to eight hours to transcribe which is a normal estimate for a non-professional transcriptionist.[366] The early transcribing of the interviews helped the researcher to remember visual details of the interviews that were not recordable. During transcribing, the researcher continued to write her perceptions and reflections in separate paragraphs within the transcripts to use them later when analysing transcripts. The transcripts were then translated from Farsi/Persian to English by the researcher. The principal supervisor of the study was an Iranian woman fluent in speaking and writing both Farsi/Persian and English. She checked the translations and randomly back-translated the transcripts from English to Farsi/Persian to ensure accuracy. She also re-worded some statements to increase intelligibility of the contexts in English.

To get a sense of the whole and become familiar with the collected data, the researcher read the transcripts and listened to the audio-tapes several times.[365] Reading each transcript in both original and translated versions several times immersed the researcher in the data to give a sense to each experience and generate preliminary ideas.[367] The researcher constructed a summary table including each participant's socio-demographic characteristics, and summaries of their pre-migration, transit, and post-migration experiences, and coping strategies which appeared interesting for analysis. Each

transcript was read along with the summary table for better understanding of each interview context.

Second, each transcript was coded line-by-line to build concepts and categories. Coding of each transcript brought a better understanding of experiences based on each participant's own story and socio-demographic characteristic. Through manual coding, relevant statements that directly pertained to the participant's experiences were highlighted and inserted into columns in an Excel spreadsheet under relevant codes.[365] Each statement could reflect more than one code. At this step, the codes with their corresponding statements were grouped together. Then the statements that were describing the same concept were categorised under a code name that fitted the best.

Third, the analysis started to take shape with shifting from codes to themes. Considering the epistemology of constructionism, the researcher constructed or generated themes that were latent in the narratives.[365] Through reviewing the coded data, the areas of similarity and overlap were identified. Then, the codes that seemed to share similar features were collapsed to reflect a meaningful and coherent pattern in the data. For example, the codes that reflected inability to verbally communicate or inability to advocate personal rights were condensed under one theme named 'language deficiency'. In the process of grouping the codes, some codes did not fit to any theme. These codes ended up as new themes or were discarded.

Fourth, the researcher reviewed the emerged findings to check for the quality and relationship between the coded data, entire data set, and emerged themes and sub-themes.[365] Themes were clarified or redefined as needed. For example, the theme 'cultural incongruity' was created from reframing the preliminary theme namely 'culture shock'. Cultural incongruity allowed for accounting for both positive and negative aspects of

encountering a new culture. Moreover, the preliminary theme of 'language deficiency' was evolved to 'social exclusion'. The new theme demonstrates that poor language skills to communicate needs and advocate rights led to social isolation, preventing some participants from building new social networks.

Fifth, unique and specific names were allocated to each theme and sub-theme to avoid repetitions and overlaps.[365] At this step, the researcher reviewed the themes and sub-themes several times, ensuring the study aims and questions were addressed. The constructed themes and sub-themes were discussed with the supervisors to reach agreement. At this step, the conceptual framework that emerged from the integrative literature review[112] and concepts of the RBM helped the researcher to further explore the relationships and rename themes and sub-themes if needed.

In the last step, the researcher reported constructed themes and sub-themes. This step occurs when a set of themes and sub-themes are ready to be written up. The researcher provided her own interpretation of each experience and included interesting, coherent, concise, logical, and non-repetitive excerpts of the participants' stories across themes and sub-themes.[365]

4.3.4.2 Analysis process

The researcher preliminarily analysed each transcript once produced before the subsequent interview to develop preliminary codes. The early analysis that included the first and second steps of thematic analysis in the previous section, directed further interviews and data collection processes.[367] At the point of the third interview, the researcher circulated the transcripts in English to the study supervisors. The supervisors preliminarily analysed the transcripts and provided their feedback about the interviews' progress, weaknesses, and strengths. The early feedback helped the researcher to develop

her interview skills and refine questions of the interview guide. At the point of nine interviews, the researcher in consultation with the supervisors stopped data collection to pull together the findings of the preliminary analysis and check for possible saturation of data. At this stage, the researcher circulated the preliminary analyses along with the transcripts in English and the summary table to the supervisors. To increase the rigour and credibility of the findings, two transcripts were analysed separately by the supervisors and the researcher. Two supervisors, moreover, reviewed the analyses that were undertaken by the researcher and sent their feedback to the researcher to develop coherence and plausibility of emerged codes and interpretations. At this stage, the researcher and supervisors reached an agreement that additional data collection was required because new issues were surfacing in each interview.

Preliminary analysis of interviews yielded four main categories of data for each phase of migration: 1) social issues that included perceptions and understandings of the participants of their social status and level of communication with their surrounding environment, 2) cultural issues that consisted of the participants' experiences of living in a traditional society in Iran and their experiences of living in a new and unfamiliar culture in Australia, and 3) coping strategies that were applied during the three phases of migration to maintain their wellbeing. For the post-migration phase a further category was identified: 4) utilising healthcare services that encompassed experiences of access and using the services in detention centres and in the community.

Once the researcher received feedback from the supervisors about the preliminary findings, she undertook further steps of thematic analysis. As detailed in the previous section, some categories were collapsed into others and new themes were created to best fit the research aims. For example, the two preliminary categories of social and cultural

issues for post-migration phase were evolved to themes including living with insecure residency and living with cultural incongruity. While preliminary categories were designed in a way to present superficial information about experiences of the participants, the further analysis moved in-depth to extract conceptual accounts and construct meanings and knowledge. After finalising analysis of the transcripts, the researcher designed a conceptual map including the constructed themes and sub-themes. The researcher presented the map in a supervisory meeting and justified each theme and relevant sub-themes. This facilitated the research team to have a general and comprehensive picture of the study findings. Through the meeting the researcher obtained clear hints and key points to refine themes and sub-themes to make them more comprehensive and relevant to the research aims and develop future analysis.[368,369] The same process was repeated for the further eight interviews.

4.4 Strengthening the rigour and trustworthiness of the research

Qualitative research carries considerable risk of bias.[370] As Lincoln and Guba (1985) state, trustworthiness is established when outcomes reflect the meanings of what participants say as closely as possible.[371] Trustworthiness is obtainable through rigorous scholarship using well-defined procedures.[370] To mitigate and decrease bias, a variety of strategies were employed in this study. Strategies used to facilitate rigour align with the four criteria recommended by Lincoln and Guba (1985); credibility, transferability, dependability, and confirmability.[371]

4.4.1 Credibility

Three approaches were undertaken in this study to ensure the credibility of the results.

1. Prolonged engagement: the researcher's relationship based on trust and rapport with the participants facilitated the gathering of rich and descriptive data that is required in qualitative research.[372] The period of six months that the researcher spent with Iranian asylum seeker women prior to recruitment through attending the community weekly events facilitated communication between the researcher and the potential participants. During this period, as detailed in Section 4.3.2, the researcher used strategies to ascertain her honesty to the potential participants. The resultant trusting communication comforted both the researcher and the participants with conducting the interviews in the participants' homes.
2. Peer examination: is used to enhance credibility and ensure validity of the findings of a qualitative research.[373] Qualitative research requires one-by-one analysis of the transcripts that is a unique process between a researcher and the collected data. Thus, it is not expected that two researchers analyse the same data in the same way. The purpose of peer examination is to see if the researchers agree with the retrieved codes, themes and the logical path taken to reach them.[373] For this purpose, three transcripts were analysed separately by the supervisors and the researcher. Then, they met to discuss differences and similarities. For other transcripts, the researcher had regular meetings with the supervisors as impartial peers to discuss the transcripts, codes, emergent themes and sub-themes, the structure of reporting findings, and the final report. The discussions through the meetings increased credibility of the findings. It was particularly useful that one of the supervisors understood the language and background of the participants. She was able to clarify concepts and validate interpretations.
3. Member checking: transcripts or findings are returned to the respondents to check for correctness and resonance with their narratives.[374] In this study, due to

reluctance of the participants for further contacts, the researcher sought clarification or confirmation from participants during the interviews. When the researcher was not certain about correctness of her understanding of an experience, she asked the participant to elaborate on the experience. Then, the researcher repeated her understanding to ensure its accuracy.[375] This enhanced the credibility of data collected, findings, and rigour of the study.

4.4.2 Dependability

To ensure dependability of the research method, an audit trail was established. The audit trail assisted the researcher to transparently explain the data analysis process of the study in detail to ensure that the study findings were consistent and repeatable.[372] All transcripts, notes, and raw data were maintained and preserved for review.

4.4.3 Transferability

Transferability refers to the degree to which the findings of a qualitative research can be transferred or generalised to other settings or contexts. To enhance transferability of a qualitative study, researchers should present a thick description of the data to provide the opportunity for future studies to include the results of this research when discussing their findings about similar or different populations.[371] Describing an event in adequate detail assists other researchers to evaluate the context to which the outcomes drawn are transferable to other times, locations, conditions, and populations.[371] The thick description was provided not only about findings, but also about the research design, including the study inclusion criteria, number and demographics of the participants, the community involvement and recruitment, data collection process, data analysis, and strategies to ensure rigorous and ethical considerations were applied.[376] Due to the small

sample size, there is no claim that the findings represent the views and experiences of the larger population of Iranian asylum seeker women, but instead the thick description provides detailed information of the study to allow comparisons to be made.[376]

4.4.4 Confirmability

Confirmability of the study was enhanced through checking and re-checking the collected data and findings to minimise bias in interpretation of data and increase trustworthiness. The researcher sought independent reviews of her interpretations from supervisors to reduce the risk of bias in the final report. The supervisors assessed and evaluated the research findings and proposed recommendations for revision and improvement.[371]

4.5 Ethical considerations

Approval to undertake this research was granted by the University of Technology Sydney Human Research Ethics Committee (UTS HREC REF NO. 2014000363) (Appendix 14). The conduct of this study adhered to the National Statement on Ethical Conduct in Human Research guideline.[377] Details on ways in which ethical considerations were addressed are described below.

4.5.1 Research with a vulnerable population

Researching a socially, politically, and economically marginalised population requires several ethical considerations. Asylum seekers in Australia are amongst the most vulnerable populations as they live with no legal protection and experience a high level of mental and physical health issues.[378,379] Two main ethical issues must be addressed in research with vulnerable populations. First, participants and researchers in such studies may require entering a relationship to establish trust. Second, research participants may

not be reimbursed for their time and effort. These considerations underscore participants' protection.[377]

In addition, in studies on vulnerable populations participants may perceive exploitation. This perception may relate to the researcher coming from empowered circumstances, and participants may be manipulated due to their deprivation from even basic rights, such as work and study.[380] To minimise the sense of being disregarded in the participants, the researcher applied the following strategies.

1. A relationship based on trust and respect was established between the researcher and the participants prior to recruitment through involvement in the community activities. This facilitated a recruitment with a minimal judgemental attitude or behaviour from the researcher against the participants.
2. Recruitment was continued through snowball sampling in which new participants were introduced to the researcher by their acquaintances, friends, or family members. Recruitment through snowball sampling facilitated rapport and trust between the researcher and the participants.
3. Interviews took place in the participants' homes to facilitate privacy and avoid transport and childcare expenses. This also made it easier for the participants to manage their time, and do interviews in a comfortable and private space while looking after their household so as not to cause burden.
4. The participants were informed about the possibility of experiencing some emotional distress during interviews as a result of talking about their past experiences. During the interviews, some participants did become emotional due to recalling heartbreaking stories or losses they endured. In these situations, the researcher offered to pause the interview, reschedule, or wait until they felt

comfortable to resume. None of the participants wished to reschedule the interviews. In addition, in the cases that the participants became emotional recalling their past experiences or their current difficult situations, the researcher recommended that they seek help from their general practitioner or counselling services specific for asylum seekers and refugees, such as the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (NSW STARTTS). The researcher gave contact details of NSW STARTTS to the participants if interested.

5. The participants were informed that their involvement in the research would have no direct benefit for them. However, their contribution would shed light on the circumstances asylum seekers face and potentially inform new or change of policies, services, and supports for themselves in the future or future asylum seekers.

4.5.2 Confidentiality and informed consent

Confidentiality is a critical ethical consideration in research with vulnerable populations, in particular for qualitative research. Compromising confidentiality may damage vulnerable populations' trust in researchers and taking part in future research projects. Breaching confidentiality may also lead to harm and negative consequences for participants.[337,381] Due to the relatively small population of Iranian women living in Sydney,[382] negligence in maintaining confidentiality of study participants might expose the participants at risk of being identified, misjudged, and betrayed by the people from the same community. Furthermore, due to lack of work permission, those who were involved in paid work were concerned about their identity being exposed to the government. To protect participant confidentiality,[381] they were asked for their first name

only; however, pseudonyms replaced names upon transcription. Moreover, all identifiable information, such as their children's names, was removed upon transcription.

Obtaining informed consent is another significant ethical consideration in health research studies that is approached in various ways including written and verbal informed consent. However, in sensitive topics such as research on asylum seekers, obtaining a written informed consent can lead to suspicion or concern about anonymity, confidentiality, or imply lack of trust.[383] In addition, in many non-Western cultures, signatures are used in major life events and leave a record of participation. Therefore, those who prefer anonymity may hesitate to provide written informed consent.[383,384] To reduce distress and distrust in the participants and ensure them of the confidentiality of their data, verbal consent only was obtained.

Prior to commencement of each interview, the researcher re-introduced her affiliation and aims of the study while the recorder was on. The participants were reminded that their participation was voluntary and that they could choose to stop interviews at any time without penalty.

4.5.3 Data management and storage

Data management is a critical step in complying with ethical considerations. Ensuring confidentiality of the participants is realised through a reliable data management and storage system.[385] In this study, the information obtained from the socio-demographic information sheets, which were attached to the relevant transcripts, was considered only for the purpose of the research. Names were not recorded on paper and the researcher was the only person who knew the identity and contact details of the participants. The contact numbers were saved with pseudonyms in the researcher's private cell phone which was

secured with a password. After completing the data collection and analysis process, the researcher removed all the contact numbers. Audio recording was used to record data collected via face-to-face interviews. All audio recordings and transcripts were stored in a password-protected computer and a secure internal university drive accessible only to the researcher and the supervisors. The audio files were deleted from the recorder after each transcription was completed. All audio recordings, transcripts, and field notes will be destroyed five years after completion of this study.

This chapter outlined the research design, data collection procedure, and thematic analysis of the collected narratives. The strategies used to ensure rigour and trustworthiness of the study findings and ethical considerations concerning research on vulnerable population were detailed. The findings of the analysis of the interview data are presented in the following three chapters. Chapter 5 provides findings of the analysis of the participants' experiences before migration and during transit to Australia. In Chapter 6, findings of the analysis of post-migration experiences are provided. The chapter includes the participants' experiences in detention centres and their resettlement experiences in the community. Chapter 7 describes the strategies that the participants applied to build resilience towards difficulties of living in a new socio-cultural environment with an asylum status and to maintain their psychological wellbeing.

Chapter 5: Result (1)

Embarking on the perilous journey

5.1 Introduction

The aim of this study was to explore the socio-cultural experiences, needs, and health status of asylum seeker women from Iran, whose refugee requests were under process at the time of data collection. The RBM helped in constructing the different phases of migration. It provided the researcher with a lens through which to explore participants' experiences, the influencing factors, and the relationships among the factors. While the themes generally emerged from open coding, as described in 4.3.4.1, the RBM informed the structuring and presentation of the study themes and sub-themes. This chapter presents the participants' socio-demographic characteristics followed by their experiences prior to migration (Section 5.3) and while in transit (Section 5.4). The participants described their reasons for leaving Iran as being disempowered as women in a patriarchal culture and to sacrifice for their families. They also presented several losses they incurred during transit, including loss of safety (feeling of safety)/security and loss of control of their circumstances. Figure 5.1 illustrates the experiences of the participants pre-migration and during transit. The RBM assisted the researcher in definition, Post-migration experiences and application of coping strategies are presented in Chapters 6 and 7.

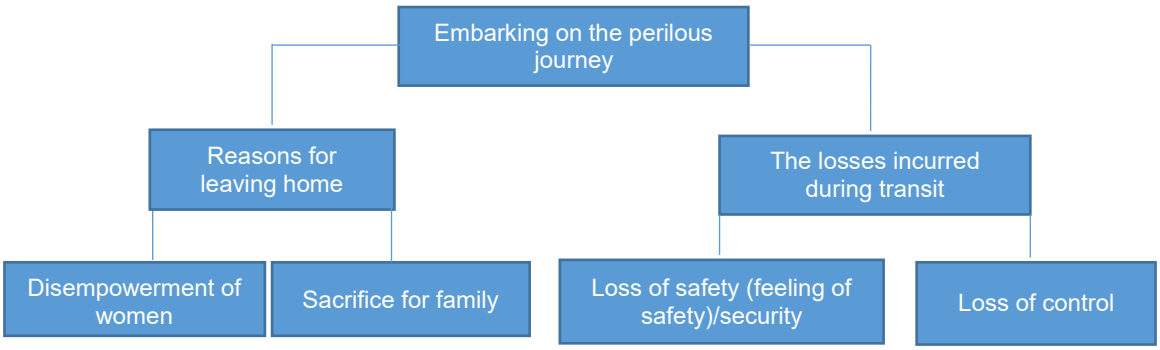

Figure 0.1: Participants' experiences pre-migration and during transit

5.2 Participants' characteristics

All participants had flown from Iran to Indonesia then crossed the Pacific Ocean by boats run by smugglers to arrive in Australia between January 2012 and August 2013. Participants' socio-demographic characteristics, including age, religion, number of children, education, marital status, employment status pre and post-migration, date of entry in Australia, the detention centre they were held in upon arriving in Australia, and length of stay in detention centres are presented in Table 5.1.

Table 5.1: Socio-demographic characteristics of participants (N = 17)

Variables	N (%)
Age	
18–30	6 (35.3)
30–40	11 (64.7)
Marital status	
Married	9 (53)
Separated	3 (17.6)
Divorced	2 (11.8)
Never married	3 (17.6)
Number of children	
None	5 (29.4)
One or more	12 (70.6)
Education	
Up to grade 12	7 (41.2)
Bachelor degree	8 (47)
Master degree	2 (11.8)
Employment in Iran	
Employed	12 (70.6)
Unemployed	5 (29.4)
Employment in Australia	
Employed	8 (47)
Unemployed	9 (53)
Self-rated economic status in Iran	
Low	6 (35.3)
Good	8 (47)
Excellent	3 (17.7)
Religion	
Muslim	10 (58.8)
Christian	6 (35.3)
No religion	1 (5.9)
Duration of confinement in detention centres	
Less than two months	6 (35.3)
More than two months	11 (64.7)
Detention centre	
Christmas Island detention facility	6 (35.3)
Darwin detention centre	9 (53)
Adelaide Immigration Transit Accommodation and Christmas Island	2 (11.8)

Participants had spent varying periods ranging from 28 days to four months in one or more detention centres in Australia. The length of residency in Australia ranged between 24 and 35 months, excluding the period of confinement. About half of the participants (47%) described their overall financial welfare before migration as good because they mostly had secure employment, a private home, a car, and a monthly income. Those who rented a home and had not secured employment rated their financial status as low, whereas those with more than one home, car, and adequate savings described their financial status as excellent. All participants were receiving financial assistance from the Australian Government and humanitarian organisations, such as the Australian Red Cross during the years of living in Australia. This chapter addresses the first research question "In what way do Iranian asylum seeker women experience migration to Australia?". This chapter also presents the adverse impacts of migration on the participants' health status, which is in response to the third research question "In what way does migration to Australia impact on Iranian asylum seeker women's health and wellbeing?".

5.3 Reasons for leaving home

The main focus of this study was on the experiences of Iranian asylum seeker women during their resettlement in Australia. The women's pre-migration and transit experiences were also important in understanding the challenges they faced post-migration and the impact of these experiences on their psychosocial health and wellbeing and abilities to adapt and integrate into the Australian society.

The participants were asked to describe their experiences in Iran and the reasons for leaving their homeland. Uncertainty about their refugee process and the risk of deportation, however, made some participants cautious about sharing their primary reason for migration. In general, the participants mentioned disempowerment of women and

sacrifice for their families as their reasons for migration. Regardless of what reason led the participants to leave their country, a common theme that emerged from the narratives was that the conditions in their country of origin forced them to leave their homeland. Reaching safety and freedom, and human rights, such as equal rights for women, pulled nearly all of them to immigrate to Australia.

5.3.1 Disempowerment of women

Six participants described their perception of feeling disempowered as a woman in Iran, a country with a strong patriarchal culture. Gender differences and lack of support within families and society, as well as the justice system, were described as disempowering these participants to stand up for their rights. One participant began her story by describing her position as a female in a patriarchal family where she was assaulted and humiliated by her father. Living in the patriarchal culture and not receiving support from her family just because she was a female resulted in having low self-esteem, feeling discriminated against, fearful, desperate, and disempowered since childhood. She noted frequent suicide ideation over her life, and related the suicidal thoughts to long-term suffering from the domestic violence and humiliation at home. She perceived a similar sense of discrimination in the justice system when she stood for her rights against her father as a symbol of patriarchal culture. The resulting sense of powerlessness to control her life and her environment contributed to feeling unvalued as a woman in the society.

> *I had a very nasty and crazy father … He wasn't normal [mentally]. I was in tension from childhood … would witness my mother being beaten by my father. My father beat me and broke my hand after marriage. I sued him. The judge told me 'you don't have the right to sue your father. Your husband can sue him but not you' … I wasn't normal [mentally] due to these tensions. I had difficult days while I was growing up … My father liked to get rid of me*

because I was a girl. I was disregarded because of being a girl ... My dad didn't allow me to study. He told me 'even if you become a doctor, you will still have to wash [your baby's] clothes' ... I didn't have calmness at all. I thought about suicide several times but I didn't do it because of my daughter. I am like a dead person who walks. I came here to reach justice. (Paria, 40)

As a woman, she found it difficult to live in the society where her human rights were constantly violated. This motivated her to immigrate to Australia where she believed that she could rely on the law to protect her dignity and human rights.

Another participant explained that she was unable to obtain a divorce in Iran. Despite being a victim of domestic violence, the justice system did not support her decision to end her marriage.

My husband became addicted ... he didn't work, beat me. My mother kept telling me 'get out from your husband's home, he will kill you'. So, I decided to divorce. I kept going to the police station every day. They [police] didn't protect me. I went to the court ... I received a letter [from the court] stating that I will not receive any alimony ... Then I hired a lawyer, but it didn't help. I kept going to the court, too much stress. My hands and legs were shaking [in the court]. I was in trouble from this court to another court ... He [my husband] didn't divorce me ... I was sick mentally, I had become crazy ... My friends told me 'leave Iran'. Some others have done this and got divorced. You can go there [overseas] and get divorce'. (Shadi, 29)

This participant believed that lack of authority to appeal for her human rights on one hand, and feeling unsafe and unsupported for domestic violence on the other, compelled her to embark on a risky voyage to Australia where she hoped to reach safety and be supported as a woman.

When successful in obtaining a divorce, this study's participants revealed further survival challenges and difficulties. A negative patriarchal attitude against divorced women, on one hand, and a lack of financial support from formal and informal resources on the other, particularly affected women from lower social status. Living in a patriarchal space where a divorced woman is at risk of sexual abuse in the workplace made it almost impossible for one participant to assume all expenses for her son and herself after divorce.

> *If they [employers] noticed that [you are divorced], they would abuse you. They [employers] would hire you only for sexual attractions … I went twice for interview. The employer of one company told me I hire you if you be my girlfriend. He wanted to abuse me, sexual abuse. I didn't accept … I was under pressure. I couldn't afford taking care of my child. If I wanted to keep my child till he was seven-years-old, my husband wouldn't support financially … I didn't get any support through the court system. I had heard that children can live with their mothers till seven years of age, but getting a child's custody is a real challenge for women. In addition, even if the court gives the custody to a mother, there is no financial support [for the mother from the court]. (Shiva, 30)*

In addition, this participant was left unsupported by her under-resourced family. Her patriarchal family with limited financial resources not only did not demonstrate any desire to support their daughter, but also blamed her and left her alone when she needed their support to appeal for custody of her child. They believed once a daughter/sister gets married, she has no right to seek support from her family. She believed that the negative attitude of the society against divorced women, lack of supportive resources from the government, and lack of support from her family, altogether, resulted in the loss of her child. The loss imposed a sense of being disempowered and devalued as a woman in the patriarchal society where she could not stand for her right to even see her child after divorce.

[After divorce] my ex-husband started to disgrace me while my son was living with me [in my father's home] … My brothers couldn't tolerate my ex-husband's behaviour who kept coming to my father's home shouting and disgracing me. So my brothers asked me to give him [my ex-husband] his child … I felt that I lost my child. I felt that they [my husband and the court] stole my child. I would beg him [my ex-husband] to let me see my child once or twice a week … I could claim the custody of my child but who could afford his expenses? My dad was too old to look after my child … You know, I wouldn't have any support. If my family or the court had supported me, I would have my child with me. I did everything for him [my child], but I couldn't be a real mother for him … Nobody could understand this, even my sisters … I wish my child was here with me, if he was here I would feel happiness, but unfortunately he is not here. (Shiva, 30)

Being disempowered and sometimes offended as a divorced woman pushed this participant to immigrate to Australia where she expected to receive support and obtain the opportunity and power to plan to reunite with her son in the future.

Another participant, who immigrated to Australia with her husband, talked about financial problems as the main factor pushing them to leave Iran. The loss of her job after marriage again reflects a patriarchal culture in which a male employer could change a female staff's job status because of marriage. Financial hardship following job loss forced her to leave Iran wishing for an easier life in Australia.

Our living condition could be good if my husband and I were working … When I was single I was working in a private surgery. Soon after marriage, my employer told me 'you must be single to work here'. It was shocking. I even couldn't complain … It [loss of job] ruined all my life and dreams. (Ana, 37)

In addition, three participants claimed that despite having good social lives and being financially well-off in Iran, they immigrated to Australia to be able to freely express

themselves. For example, one participant, who said she had good social and financial status as an educated and full-time employed woman in Iran, described that she was affected by the rules that deprived her from following her basic human rights, such as freedom of expression of her beliefs.

> *My main reason for immigration was my country's social condition that I was suffering from for many years. No calmness, no comfort. I had a very good financial status, but unfortunately no calmness. The most important thing, I wasn't comfortable out of my home. I had social problems, lack of social and religious freedom [in Iran] … It was not only about wearing [scarf]. It was about expression of beliefs. I couldn't freely express my beliefs, religious beliefs, political beliefs in public. If I did, I would be arrested. I really didn't feel stability and safety about my social life, job, and future. I was always at risk of losing my job … Many [asylum seekers] have immigrated because of financial problems in Iran. But I had no financial problems. My problem was deprivation from my rights as a human. I was scared of having a date due to the risk of being arrested. It could endanger my grace and job status. (Roya, 34)*

The excerpt above depicts a sense of lack of dignity, safety, and freedom in Iran, which pushed the participant to seek these human rights in another country.

In light of the dominant patriarchal culture in Iran, the participants perceived their situation as hopeless, triggering their decision to leave their country, family, and all the resources they had in their homeland with a hope of attaining dignity, value, and power in a host country. The women above had various socio-demographic characteristics. Three of them possessed academic qualifications and were employed before migration. Two women were did not work nor had academic education. Regardless of the differences in social status, these participants shared similar experiences and perspectives about their situation as a woman in Iran. In general, the common point of the women above was that

they experienced gender discrimination, abuse of their basic rights, and unemployment, and consequently felt unvalued and insecure. Since the negative experiences were generated by poor social justice and the dominant patriarchal culture in Iran, they felt despair of any change, and saw the only solution as leaving their country, family, and all resources they had in their homeland.

5.3.2 Sacrifice for family

Sacrifice for family was described as a main reason that compelled four participants to flee Iran. Two participants talked about their husbands who were prosecuted for their political activities, while one participant reported her own involvement in religious activities, which placed her at risk of being arrested. Nonetheless, all three women claimed that despite their reluctance to leave their country and family, they eventually emigrated in order to save the lives of their husband's children. The women perceived this action as a sacrifice for the family as they lost their family, friends, and social status to help their husbands and children attain peace and safety in Australia.

A participant, who was a housewife in Iran, talked about her 'comfortable life' before migration. Her husband's high social and job status provided them with financial security and social reputation in their area of residence. However, following her husband's political activities, the whole family, including her young son, was at risk of incarceration. Although this participant was aware that migration would risk their socio-economic status, she agreed to accompany her husband and children to Australia to save their lives.

> *My life was not bad in Iran. My husband was a barrister. And many people knew us in our city. We were credible … [My husband's] income was good. My children's clothes and food were ok … I always had money in my bag … They [my husband and his colleagues] wrote a paper against Arabs at the*

university. They released some facts … my husband was arrested for 36 days and we didn't know where he was … his barrister registration was cancelled and had no work permission. Once, they [police] disturbed my son. Then my husband told [me] 'I cannot stay in Iran. If I stay, I will kill myself or my family's safety will be at risk'. I said 'I won't go anywhere. How can we go? Our life is here' … Eventually, I agreed. We only wanted to get out of Iran, somewhere to live. Our children to be safe, for my son … I didn't want him to be in trouble [because of my husband's political conflict]. (Sima, 39)

Interestingly, another participant whose religious activities in Iran placed her at risk of prosecution described her decision to migration as a sacrifice for her children. The excerpt below demonstrates that she had no fear of being arrested herself. However, as a mother she felt a strong commitment to ensure her daughters' safety and security, which were at risk of violation due to the participant's illegal religious activities. This sense of responsibility contributed to the participant's interpretation of migration as a self-sacrifice to secure her children.

I am a spiritual practitioner for which I was prosecuted [in Iran]. Because it is a serious offence in Iran. One day, when I wasn't at home, police entered my home to arrest me. My daughters were at home and at risk of being harassed instead of me. After that we couldn't live at that home and we left Iran in 20 days. My husband had a flight agency in Iran, two homes, shops and so on. We were very rich. We left everything behind and came here because I didn't want my daughters to be at risk. I wouldn't mind myself but my daughters were at risk because of my activities … They [my daughters] will become valued persons [in Australia]. Here is a country that values women. (Paria, 40)

This study interviewed another participant who shared her child's sickness as the reason that pushed her to leave her country. Despite strong family ties and emotional attachments

to her family members, the participant surrendered to immigrate to Australia to save her child's life.

> *My life in Iran was much better that many others. In terms of family relationship and financial status, I was better that many others … My child was suffering from recurrent seizures. Iran was in sanction of medication … [Due to lack of medication] my child could be paralysed, she might have lost her vision, and she would probably lose her ability to talk. She would be a cripple, would need a wheelchair for her life. I didn't want to see her in suffer. I would like to do everything to save her … I was the only daughter [of my parents]. It was difficult for me to leave them, but I eventually accepted to immigrate. (Neda, 32)*

In general, analysis of the narratives in this study revealed that the women left their country for two main reasons. While feeling disempowerment as a woman in the patriarchal society compelled some participants to leave their families, social status, and their homeland with a hope to reach power in another country, others felt empowered as wives and mothers to protect their families' lives and safety.

5.4 The losses incurred during transit

In this study, the transit period is defined as the time that the participants lived in Indonesia awaiting to be called by smugglers for departure to Australia, including the journey on the boat. All participants left Iran legally (via commercial flight to Indonesia holding a valid passport) and were granted a tourist visa for up to 10 days in Indonesia. However, due to unforeseen delays in their departure to Australia they overstayed in Indonesia for varying periods of time, ranging from 10 days to four months. The duration of boat journeys also varied depending on the route that the smugglers chose. Participants spent about 36 hours at sea if the destination was Christmas Island, while the journey to

Darwin lasted between seven and 15 days. Christmas Island is an external territory of Australia located to the north-west of the Australian mainland. Darwin is the capital city of the Northern Territory of Australia.

The participants depicted the boats as crowded, dangerous, and life-threatening, with inadequate food and water supplements, lack of privacy, lack of a place to rest, and even lack of life jackets. Understandably, the longer the period at sea, the worse the experience as described by participants. The transit period was experienced as a stage of several losses. Six participants perceived the transit period as traumatic and life-threatening to the extent that recalling the experiences distressed them even two to three years later. However, others described the difficult days of the transit as temporary that passed without having any serious negative effect on their health and wellbeing. In general, almost all participants perceived the transit period as 'a stressful and difficult time'; however, the experience was perceived as 'traumatic' by single women and those who were travelling with their children.

The main themes that emerged from the participants' experiences of the transit period included loss of safety (feeling of safety)/security and loss of control.

5.4.1 Loss of safety (feeling of safety)/security

Most participants described their time spent in Indonesia as frightening and anxiety-provoking. Unforeseen delays in boat departures from Indonesia meant that participants exceeded the time allowed on their tourist visas. As a result of the illegal stay, most participants experienced unsafety and insecurity which forced them to live in hiding for extended and uncertain periods. The women's children were likewise afraid.

> *The last days [of staying in Indonesia] [pause] ... Our visa expired ... We would hear voices overnight, we were told that police is coming, it was horrible. My son was distressed ... He still needs psychological care. Both of us, my son and myself ... The hard conditions in Indonesia made my son fearful. He was frightened overnight. (Mahsa, 31)*

This participant became emotional while she was recounting the experience of loss of safety in Indonesia that resulted in lasting mental health problems in her child. She blamed herself because of exposing her child to the condition of unsafety and stress. The experience of loss of safety in transit followed by the continuous self-blaming and emotional distraction that did not disappear over time seemed to affect this participant's mental health and resulted in ongoing need for psychological treatments.

The protracted stay in Indonesia placed children in particular at risk of hunger, contagious illness, or exacerbation of existing illnesses, which intensified the hardness of transit for those participants with children. Lack of legal status and fear of being reported to the police by healthcare providers barred these participants' access to healthcare services. The participant who left her country and loved ones in Iran to save her child's life was severely distressed when she found her child at risk of death in Indonesia. She perceived her sacrifice to be failed due to her loss of legal status and feeling of safety that threatened her child's life.

> *We had been granted a 10-day visa which expired so we couldn't get my daughter to a doctor, [because] we might have been arrested by the police. Her [daughter's] limbs would become stiff when she was sleeping and I couldn't do anything for her. She was at risk of death and I couldn't do anything for her. It was the most difficult part [of the journey]. (Neda, 32)*

Fear of being deported back to Iran was another source of stress during the participants' illegal stay in Indonesia. A participant shared her experience of being arrested in

Indonesia. Over the prolonged stay in the transit country for two months that led to being identified as illegal stayers, she dealt with a continuous fear of being deported to Iran, where she had invested her financial resources to flee the stressful conditions and reach Australia.

> *Once we were arrested by the Indonesian police. We were kept in a detention for one day … We thought that was it, we were going to be deported to Iran. I was really worried, completely desperate … [Our] living condition in Iran was awful. My family-in-law were not happy at all with our decision of immigration. I even couldn't sell my stuff for the fear of my mother-in-law … I was thinking [in the detention] if we [go] back [to Iran] I would be in trouble with my family-in-law because the smuggler wouldn't refund us. It was horrible. (Ana, 37)*

The risk of being deported to her country of origin where she had no support and no resources to compensate her financial losses was the main source of fear for this participant.

One participants also worried that they may be pursued by the Iranian police while in Indonesia. The participant, who fled Iran due to her religious activities, talked about the great deal of stress and fear she tolerated during her short stay in Indonesia. Contrary to some participants, her migration was unplanned and urgently enacted to secure her children's lives. While in Indonesia, she frequently reviewed the life-threatening events she had experienced in Iran.

> *I was in Indonesia for only 10 days but it was horrible. I couldn't tolerate there. It was very difficult for me because I left [Iran] suddenly [unplanned]. I couldn't breathe properly … I had a severe stress. I was feeling that I was being chased by the police of Iran. (Paria, 40)*

Not having time to prepare herself for facing a new environment and to adjust to her new condition in Indonesia made this participant confused and added to her stress.

The illegal migration journey also created a fear of being sexually assaulted. Although there is no report on actual sexual harassment in this study, some participants shared their sense of unsafety in their interactions with smugglers, airport officers, and even police officers in Indonesia. The excerpt below reports one participant's fear of being sexually abused by her smuggler.

> *My smuggler was a bad guy. He called me to his room one night. I was so scared. He wasn't normal because he was using drugs... Women are not safe anywhere… I told my relatives 'I am going, come after me if I am late'. I went [to his room] but I was lucky that nothing bad happened. (Shadi, 29)*

This participant narrated her reason for migration as being affected by living in a patriarchal culture in Iran where her human rights were violated because of her gender. Her fear of being assaulted because of her physical attraction as a woman recalled her pre-migration experiences and added to her stress.

While in Indonesia, the majority of the women experienced a breach of privacy for varying periods that triggered feelings of insecurity. While some experienced it only for one day before departure, others were kept in crowded places for more than one month. These properties, referred to as 'spots', were described as extremely crowded residences where people awaited to board a boat to Australia. They had to share a bathroom, kitchen, and living room with strangers, a condition that was perceived as insecure, uncomfortable, and stressful.

> *I just can tell 'horrible' … 20 people in a three-bedroom home. We stayed there for 40 days. We all were sleeping and waking up together … I remember*

> *every single hour and second … I had no idea about the spots. The only thing I had known was that we will live in a hotel in Indonesia for a while then we will be boarded on a safe ship like Titanic [to Australia]. (Roya, 34)*

This participant was highly motivated to immigrate due to social hardships she confronted as a woman in Iran. She had left a financially comfortable life in Iran, but had to live in sparse and uncomfortable circumstances during transit. Similar to the majority of participants, she recounted the difficulties she endured over the second phase of her journey; the departure and on the boats. The departure time was an important event when most participants felt a severe lack of safety. Seeing the immensity of the ocean, the dilapidated boats, and fear of being arrested by the police together frightened the participants.

> *The moment of boarding the boat is a very bad memory, very bad. The smuggler shouted 'police, sit'. We were 120 persons there. When we sat and I saw the ocean, the boat. I didn't know that. I told my sister 'I don't come. If there is a way I want to go back'. (Roya, 34)*

Experience of distress and lack of safety in Indonesia followed by travelling on a rickety, overcrowded boat made the above participant feel a great loss. She had left a financially comfortable life in Iran, but had to live in sparse and uncomfortable circumstances during transit. She was unprepared for the trials of the journey, instead clinging to stories of her Australian-dwelling friends about positive aspects of living in Australia. Facing the boat and being treated like criminals by the smugglers added to her stress and completely discouraged her, although she had no option but continue the journey.

Another participant expressed her extensive fear of travelling on an unsafe boat while she had been assured by the smuggler that she would be crossing the sea on a modern safe

vessel. The excerpt below reflects the participant's feeling of insecurity and unsafety on boarding the boat. Nearly all participants shared similar feelings and experiences.

> *We were boarded on a bad boat along with 150 other passengers. The smuggler would tell us 'there will be beds on the boat to rest. There will be a kitchen'. But we even had no life jacket. It was horrible … I wished to return to Indonesia in spite of the hardness we experienced there [in Indonesia]. (Neda, 32)*

In general, the participants compared the extent of benefits they expected to gain by leaving Iran with the resources they lost during the journey. Seemingly, fewer benefits discouraged the participants; however, those with a strong motivation for immigration stayed confident with their decision about approaching the illegal journey. One participant, for example, sacrificed all the resources she had in Iran, such as social and material resources, to save her child's life. Her own life seemed to be her last resource that she could sacrifice to protect her child from the disease that remained untreated in Iran due to international sanctions causing drug shortages. She claimed that she was neither scared of the boat, nor regretful about approaching Australia the illegal way.

> *I wasn't remorseful at all, because I knew my child is with me. Look, all people were regretted. But I wasn't. Maybe they haven't convincing reasons [for migration] but mine was convincing. All people were scared but I didn't care about the difficulties at all. Because I just wanted to save my child. If she stayed there [in Iran], she couldn't be saved. (Neda, 32)*

This excerpt depicts that motivation can help to transcend the negative aspects of the migration process. This woman was steadfast in her determination, which facilitated her coping with the journey, as it was a means to an end that she highly valued.

Loss of connection with family members was another stressful event experienced by five participants for various periods during the transit. Separation from family members at the time of departure was a burdensome experience, resulting from the chaos of the departure. One participant was disconnected from her brother and child for a couple of minutes while another woman was separated from her husband for more than 10 days. Regardless of the length of disconnection, the created sense of unsafety was devastating.

The woman who was separated from her brother was concerned about preservation of the unity of her family. Culturally, she regarded her brother as part of her immediate family, similar to her child and husband.

> *We reached the boat. I didn't board. I said 'my brother is coming and I won't board without him'. It was very important for me to be together even at that difficult situation. If we were supposed to reach [Australia], it must be all of us, together. (Neda, 32)*

While everyone was rushing to board the boat at the crucial departure time, she resisted by waiting for her brother to board together. Intending to protect her family from disunion augmented the departure stress for this participant, but made her feel safe on the boat. In addition, gossip about lost or stolen children in departure aggravated her feeling of unsafety. Although separation from her child lasted only for few moments, it was perceived as a shocking and fearful event even after two years.

> *A guy pushed us and said run. All people got separated at that bad condition. A guy pulled my child because we [my husband and I] couldn't walk. We just ran after him to not lose our child. He didn't care if a person was dying at that condition. It wasn't important for them [smugglers]. We reached the boats. I didn't see my child. I screamed and cried and asked for my child. It was a horrible moment. They [smugglers] gave me my child. (Neda, 32)*

Another participant explained that her husband was left behind in Indonesia as the boat was too overcrowded and there was no room for him. Separation from her husband while there was no means to contact him was perceived as a highly stressful experience by the participant that continued on for 10 days until they were united in the Christmas Island detention facility.

> *My husband and I boarded on the boat. An old lady came to our boat and gave a red note [Indonesian money] to the smuggler … So, my husband was gotten off the boat and I got alone …. I am a source of sureness for my husband. I knew his bad situation in Indonesia because I was not with him. Imagine, I had already gone through life-threatening experiences on the boat and would imagine all those for my husband. I mean I experienced that stress twice. Once for myself, I was afraid, I was alone, second time for my husband. (Soraya, 29)*

The separation not only increased her stress about her husband's health status, but also amplified her stressful experience of the journey on the boat. In other words, she tolerated stress of the voyage twice; once for herself and another time for her husband.

Apart from temporary disconnection from family members, permanent loss was also experienced as a result of the lack of sanity, a secure condition, and access to healthcare services during the transit period. One participant experienced loss of her cousin, who developed gastritis on the boat. She died a few minutes before arriving in Australia. The heartbreaking event affected the participant's mental health to a degree that she was still suffering from the associated mental health problems, despite receiving counselling services after three years living in Australia. The participant became emotional when taking about this event; however, she refused the researcher's suggestion to halt the interview and continued her narrative. She believed that the interview provided her with

an opportunity to express her emotions and alleviate the long-term psychological impacts of the event.

> *It was a stormy night … I fainted during the storm … When I recovered I told my husband 'we'll get there' … But after the storm I heard my cousin's husband was screaming, she died … I was scared and crying … [The participant cried]. We arrived in the Christmas Island just after her death. (Ava, 32)*

Experiences of disconnection from family members were perceived as extremely distressful by the participants, although they all ended up being united, except for one participant, whose cousin passed away on the boat.

Overall, the participants lost many resources when they left their country. Facing further losses in transit, particularly the loss of family members, was perceived as extremely stressful and frightening.

5.4.2 Loss of control

In addition to loss of safety and security, most participants lost control over their circumstances in transit. The transit period was described by the participants as a period of dependency, where they expressed a lack of power to control their situation during the journey. Using words and phrases such as 'we had to obey', 'we must', and 'we were obliged to' reflects the participants' lack of power to make decisions during transit. The women described that being under the control of smugglers, who were generally known to be 'unreliable', created a significant sense of fear and vulnerability for them.

> *We were in extremely horrible places in Indonesia. We had to. When you leave your country and go to another one, you MUST obey smugglers because you don't know anything. In your country you are aware of the rules, but in a*

> *foreign country you don't know the rules. So, you have to trust even on a smuggler, a person who is not trustable. You have to. (Shiva, 30)*

The above participant was a divorced woman who fled from a patriarchal society and a discriminatory justice system where she believed that had to obey men without the option to consider her wants and needs. Having had to obey and be reliant on smugglers during transit resembled the male-dominant culture that she had fled from while wishing to reach freedom and independence.

Likewise, another participant talked about her stressful days of living in uncertainty in Indonesia. Similar to many participants, she fled Iran to gain freedom and stability; however, her inability to navigate the journey forced her to follow the smuggler's commands in Indonesia.

> *Many people had fun there [in Indonesia], but to us [my boyfriend and me]. We were dislocated several times by the smuggler ... I was feeling like somebody was controlling me. I didn't like it. I don't like to be kept under control in a place. My father was controlling me from childhood, and I had to follow his rules, I was upset of that. I was upset in Indonesia because we had to wait, wait for what? I didn't know what would happen. What should I wait for? (Nasrin, 35)*

The above participant who was an educated woman left Iran with the hope of gaining freedom and independence; however, the experience of powerlessness and lack of control over her life in Indonesia resembled her stressful life in a patriarchal society where she was under the control of her father and had no authority to make decisions about her life.

The lack of authority to control their journey's process threatened one participant's physical wellbeing. The participant, who was pregnant when she left Iran, had been promised by the smuggler to be transferred to Australia within one week after arrival in

Indonesia; however, her stay extended for more than two months. She was in desperate need of resettlement; yet, helpless to do anything other than obey the smugglers.

> *I was 8-month pregnant. I was scared of approaching the illegal way. The smuggler told my husband 'I guarantee you will get there [Australia] in one week because of your wife's status' ... But nothing happened after one week, nothing happened after two weeks. It was getting close to my delivery date and I was concerned about my baby ... it was stressful, I didn't know what will happen if my labour starts. I would beg my smuggler to send me to Australia but he didn't care. (Ana, 37)*

Similar to the other participants, she lost her power to control her circumstances when she decided to immigrate to Australia illegally and relied on the smugglers. She had to follow the rules and the conditions that the smuggler determined, and experienced a great deal of stress due to being in the later stages of her pregnancy, worrying not just for her own safety, but that of her unborn child.

Another participant described family conflicts and loss of control over her marriage in Indonesia due to her husband's involvement with other women. Although she was awaiting her refugee application to be proceed by the United Nations High Commissioner for Refugees (UNHCR) in Indonesia, the psychological pressure resulting from the family conflicts and her powerlessness to manage her marital relationship forced the participant to withdraw her application and approach an illegal and unsafe voyage to Australia.

> *Men cannot control themselves ... There were some bad girls there [in Indonesia] ... I was agonised when my husband was talking to the girls ... I was always alone at home ... We met a friend in the UN [United Nation office] one day and he told us that he will leave Indonesia illegally soon. I was frustrated. So I told him 'we want to come with you ... I am sick of here ... I cannot tolerate this condition'. (Hale, 25)*

Her husband's inappropriate relationships were perceived as psychological abuse that she felt powerless to manage their status in Indonesia. Making the decision to cross the sea and risk her life to save her marriage reflects the high level of distress and mental pressure that this participant tolerated as a result of lack of control on her condition in Indonesia. However, her quick decision to approach the illegal way to Australia produced a greater stress for her inasmuch as she wished to return to Indonesia.

> *I really regretted it, it [the boat] was horrible … When I heard the water sound I begged them [the smugglers] to return me [to Indonesia]. I told my husband 'do whatever you like in Indonesia, just let's go back' … When the boat moved I said 'God, please forgive me. I repent of everything I have done'. I thought we would never arrive [in Australia]. It was that horrible, a very bad experience … I was scared. I thought I would die. (Hale, 25)*

In general, despite kicking off their departure with minimal information about their journey, the participants expected to be able to retain the control of the process in Indonesia. However, they found themselves powerless to make even simple decisions about their journey and living conditions.

In general, transit was experienced as a period of uncertainty, with a lack of safety, fear, and disempowerment. While some participants perceived the difficulties incurred during the transit as temporary with no serious long-term effects on their health status, others related their ongoing mental health issues to lasting negative effects of the journey.

Chapter 6: Result (2)

Arrived, yet living in-between

6.1 Introduction

This chapter addresses the first, second, and third questions of the study. The questions are “In what way do Iranian asylum seeker women experience migration to Australia?”, “In what way do Iranian asylum seeker women perceive and give meaning to their living in Australia?”, and “In what way does migration to Australia impact on Iranian asylum seeker women’s health and wellbeing?”

Post-migration experiences were divided into experiences in detention centres and in the community. Participants assumed themselves in Australia once they saw the Australian navy vessels on the ocean. The sight of the vessels assured the participants that their journey was over, although they were still on the boat. Therefore, they referred to all events afterward, including the period of detention, as their post-migration experiences.

> *I was very happy, we had been found eventually. We were well. The Australian police caught us. We could see the Australian crafts and flags around us …. Everybody was happy and relieved because we had reached the destination. We were not that well physically but we were feeling better mentally because we could see the land. The Australian navy vessel came to us after five days. We were boarded on the craft and they [officers] welcomed us. (Fariba, 35)*

The above participant tolerated the longest journey on the boat compared to other participants. A total of 15 days on a dilapidated boat and going through storms produced a sense of gratitude and fulfilment when she saw signs of Australia, such as the land, the

navy vessels, and Australian flags. Although the land was still in the distance, she felt safer. In addition, she expected to be treated like a criminal due to her boat arrival; however, she was surprised by the respectful behaviours of the officers.

In contrast, one participant criticised the behaviours of the staff at arrival, who blamed the participant for her illegal entry and threatened her with being transferred to a country other than Australia. Being treated like a criminal who should be detained or punished, was inconsistent with this participant's expectation of Australia as a welcoming country for asylum seekers and refugees. The inconsistency between her expectations and the reality was distressing.

> *They [officers] treated us very badly. [They said things like] sit down, don't move, and don't make noise … We were told in the bus 'you might be sent to Nauru' … They described Nauru as a remote island … The interpreter explained to us 'as you've entered illegally, you'll be detained'. My perspective of detention was wearing a handcuff and being in prison. [I thought] we got wretched. I said 'I've erred. I would rather die than go to jail'. We were waiting for more details, wishing he was kidding us … They [officers] made us cry. (Hale, 25)*

This participant had left Iran with hopes of reaching freedom, support, and a sense of dignity that could assist her in building a better future. However, the experience of being detained and humiliated upon arrival in Australia was shocking. Figure 6.1 illustrates the experiences of the participants after arriving in Australia.

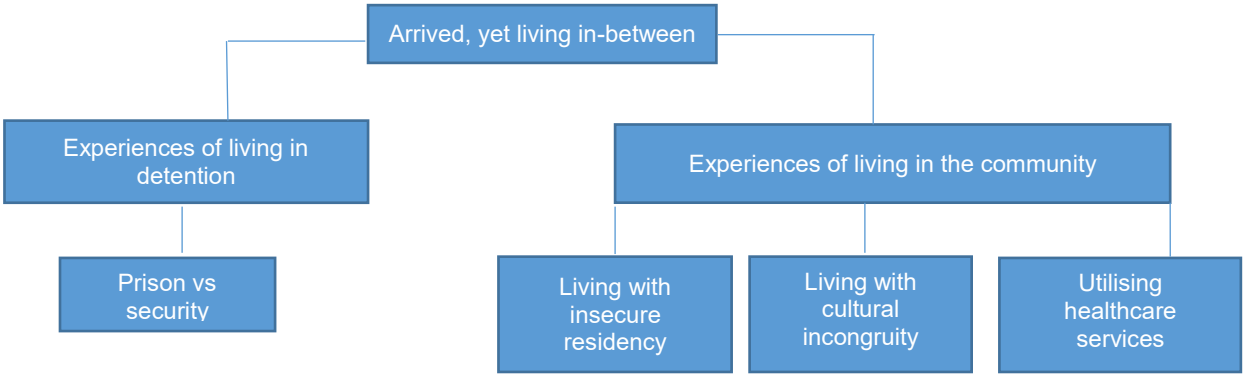

Figure 0.1: Participants' experiences after arrival in Australia

6.2 Experiences of living in detention: prison versus security

The participants shared their experiences of living in detention centres, which were the first residences they stayed in for a period ranging between 28 days and four months after crossing Australia's borders. Experiences varied at the different detention centres. According to the participants' reports, they were mainly held in one of the three centres – the Christmas Island detention facility, the Darwin detention centre, and the Adelaide Immigration Transit Accommodation (ITA). The participants' experiences of services (including healthcare), and the way they were treated by detention officers were substantially different at these centres. The participants (n = 11), who were detained in the Darwin detention centre or the Adelaide ITA mainly reported positive experiences, while those (n = 6) in the Christmas Island detention facility complained of their living conditions. The following section presents their experiences of detention.

Most participants in this study had been aware of Australia's compulsory detention policy before arriving; however, others learned about the policy upon arrival. These participants were shocked at being treated as criminals and obliged to spend time in a prison-like environment. They knew Australia's reputation as a country that welcomed people

seeking freedom and safety, and compulsory detention was inconsistent with their expectations. The prison-like environment of the detention centres was the first negative experience nine participants could recall after arriving in Australia. The excerpt below describes one participant's shock at facing the physical structure of the Christmas Island detention facility, which had been designed for criminals, and she perceived it as punishment for her boat arrival.

> *Look … I moved to Australia to live a life better than what I had in Iran. But we were kept in a prison. We were given a room in the camp, a bunk bed, my husband had to sleep up and my son and I down. The toilet was shared with other rooms. It looked like a cage … Officers entered occasionally into my room without knocking the door … I wanted to go back to Iran from the Christmas Island detention. (Elena, 28)*

The participant above was an educated woman who claimed having a very high socio-economic status in Iran. She expected a more comfortable living condition compared to what she had left behind. However, what she encountered in the immigration detention was completely different from her expectations. Although she was regretful of her decision to immigrate to Australia following the difficulties of transit and the conditions at the Christmas Island detention facility, she felt freedom and respect as a human when she was transferred to the ITA.

> *Then we were transferred to Adelaide and given a big three-bedroom house. I calmed down … We stayed in Adelaide for two months. Adelaide was very good. We were given $170 voucher to shop weekly. We were given moisturiser cream and even special soaps for our skin acne. (Elena, 28)*

Another participant shared her experience of living in an enclosed environment where she perceived her freedom was restricted. She stated that her son, who was only four-years-old, perceived their lack of freedom to move out as a punishment for an illegal action his

parents had done. To be seen as a criminal or guilty person by her child added to her distress.

> *My son would tell me 'mum, why we are in the prison? Did you do any bad thing?' It was a closed environment. We liked to get out. We wished to become free. It was a beautiful sense when we were released from the detention. (Mahsa, 31)*

Past experience of illegal status and fear of being arrested by police in Indonesia followed by being confined in an enclosed environment in Australia made her child sensitive, wondering if his parents were criminals. Since it was beyond his understanding to comprehend the meaning of illegal entry to the country and Australian immigration policies, he assumed his parents were responsible for their confinement. The participant expressed her distress at being viewed as a criminal by her child while living in detention.

Apart from the prison-like environment of detention centres that created a sense of being criminals who deserve the punishment of confinement, some participants perceived detention as a symbol of control and power. For those who had experiences of being powerless and under control in a patriarchal society in Iran, it was particularly difficult to find themselves under control and powerless in Australia, the country where they had expected to reach freedom and power.

> *We were given clothes, food, I asked 'what are these?' We were ordered 'you should sleep there'. 'You shouldn't do this'. We were examined by doctors. I asked my partner 'what is going on? We are prisoners here, do you realise?' [My partner] said 'no, why do you say so? This is a process that should be done'. I said 'why you don't realise? We are prisoners here' ... My father was controlling me from childhood, and I had to follow his rules. I was a prisoner in my home [in Iran], and in my country ... It was a very bad feeling*

because I was looking for a place to live free … I don't like to be kept under control. But in the detention I was under control. (Nasrin, 35)

While being accommodated and cared for in detention created a sense of being welcomed in some participants, this participant perceived it as a sign of humiliation and loss of power. Her previous experience of living in a patriarchal family and society for many years probably made her sensitive to the events occurring in the detention centre. Her distress may also have arisen from expecting a different experience, as she earlier stated that she was unaware of Australian policies and trusted completely in her partner, who did not share this information.

With respect to the concept of control in the detention centres, one participant shared her experience of being separated from her siblings. She explained that refusal of her request to stay with her siblings in the detention centre gave the message that she was under control of the authorities while detained.

We [siblings] said we are together, but they [detention officers] told us 'here is Australia, sisters and brothers are not part of family. You and your husband and your child are a family' … My sister was detained in the single detention … My sister was transferred to Adelaide, my brother to Brisbane … I am very dependent on my sister. It was important for me to be with my sister. If she wasn't with me I might have not come to Australia with my husband We had to stay in different cities for a while [after release into the community]. (Ana, 37)

On the whole, the above participants perceived detention as punishment for their illegal crossing of Australia's borders. In addition to the negative experiences mentioned above, one participant perceived healthcare providers' behaviours to restrict her access to the services as punishment. She immigrated to Australia to seek appropriate medical treatment for her child, who was suffering from a life-threatening disease. She expected

medical services and medication to be available to help her child's health; however, having limited access to the services in the detention centre disappointed her.

> *I just thought I was going somewhere [Australia] where there is a hospital and a pharmacy to give medicine to my daughter … in detention, my daughter would wake up at 5 am every day, crying and screaming. I had to take her to the yard and wait for the doctor in the cold weather till 8 am … It seemed that they [doctors] had been told not to care about us … Once I went to the doctor for my sickness, I was asked 'why you are here [medical centre] again? Tell us honestly what do you want from us? Why do you come here every day? (Neda, 32)*

While a misunderstanding could have caused the above experience, this participant linked the healthcare providers' behaviours to their political attitudes, which she thought were under the influence of immigration policies against boat arrivals.

Apart from the negative experiences of living in detention centres, this study revealed some positive aspects. First, eight participants described their sense of being secure in a safe and protected environment. The excerpt below belongs to a participant who fled Iran with her husband and two children whose lives were at risk due her spiritual activities in Iran. Due to this background experience, she felt safe in the detention centre.

> *I am a spiritual practitioner, which I was prosecuted for [in Iran]. Because it is a serious offence in Iran … In Indonesia I was feeling that I was being chased by the police of Iran. I was frightened. … [But] the detention centre was safe and peaceful … I was mentally fine in the camp … I would feel safety and peace in the camp. (Paria, 40)*

In addition, some participants appreciated being accommodated and supplied with what they needed, particularly in the Darwin detention centre and the Adelaide ITA. One participant, who recounted her experience of gender discrimination in Iran that

disempowered her from affording her requirements, expressed her gratitude for the services in detention. The excerpt below presents the participant's satisfaction with the level of care and services she received in the detention centre inasmuch as she wished to stay there for a longer time.

> *It [Darwin detention centre] was beautiful. We were in a family detention, they would care about us very much. It was clean. They [officers] looked after children. For example, they gave formula to children, nappy, moisturiser, everything for children, many clothes to my child, vaccination. Doctors and health services all were available … It was like a hotel. I didn't like to live outside. (Ana, 37)*

In addition to financial benefits, this participant built and developed her social networks in detention, which could partially compensate for the loss of her extended family and friends through migration.

> *In detention, we made some friends there. I was separated from my sister in the detention but my new friends supported me. I would spend my time with them and wished to see them again outside [after release to the community]. (Ana, 37)*

Moreover, for those who travelled with their children and husbands it was a critical positive point of being united and safe in detention. One participant depicted the Darwin detention centre as 'paradise' when she reviewed the life-threatening events during the dangerous journey to Australia. She was grateful for being cared for in detention, which helped her recovery from her previous life-threatening experiences.

> *Detention was like paradise. We had been saved from death. My children, my husband, we were alive … When we arrived in Darwin, it was like paradise for us … My God, here is a paradise … there was food, they [officers] were kind to children, and there were doctors for sick children. (Mahsa, 31)*

Moreover, provision of training and entertainment activities that provided asylum seekers with some skills, such as sewing, knitting, and English language skills, were perceived as positive aspects of detention. The participants said that the activities not only gave them a sense of being welcomed in the host country, but also helped them to gain skills that may ease their resettlement in the new society in the future.

> *I liked it [Darwin detention centre]. It was beautiful. My room had a bed, bathroom, TV, wardrobe and a refrigerator. [There was a] volleyball court. We were taught to manicure, thread, knit and sew. They [detention staff] gave us sewing facilities. I assumed that I could find a job as a sewer after release into the community … There was a gym. We were very happy, because they [detention staff] provided everything we needed. Some people would attend English classes. It was very important to know English [language], although I did not attend. I am remorseful for not attending [English language classes]. (Shery, 40)*

Contrary to two participants who expressed their dissatisfaction of healthcare services in detention, one participant appreciated the quality of the services and the appropriate diagnosis and adequate treatment that her daughter received.

> *[In the Darwin detention centre] I was told that my daughter had tuberculosis. It was the first time I was hearing about this disease … I was crying. They [doctors] told me that 'it is not serious. If it was we would isolate your daughter'. They treated my daughter and now she doesn't have any problem. (Zahra, 27)*

Although the routine medical examination upon arrival in Australia in detentions was perceived as a means of control and humiliation by some participants, this participant recalled it as positive treatment that helped asylum seekers to feel welcomed and empowered in the host country.

In general, most participants perceived compulsory detention as a threat to their mental health and as a wasted life. According to the interviews, the period of detention could have been used as an opportunity to help the participants settle in Australia – a culturally and linguistically diverse society. However, the conditions of the detention centres and in some cases discriminatory behaviours of the staff and officers, left the participants disadvantaged. Moreover, participants believed that the highly politicised environment of the detention centres affected their living conditions and their access and utilisation of healthcare services.

6.3 Experiences of living in the community

The main purpose of this study was to explore the participants' socio-cultural and health needs during resettlement. This section presents the participants' experiences of living in the community, how they constructed meanings for their experiences, and how these experiences affected their health and wellbeing. Analysis of the interviews revealed three main issues that the participants confronted over the years of living in the community, including living with insecure residency, experience of cultural incongruity, and using healthcare services.

6.3.1 Living with insecure residency

According to the interviews, participants expected to be released into the community with permanent residency status.

> *Before coming to Australia, I saw a friend in a party [in Iran]. He was going to fly to Indonesia in one month. He told me 'I gonna go to Australia by boat'. He told me 'Australia is a paradise ... When you reach there, you will be hosted in a centre to be examined for your health. This process may take only a couple of weeks. After that you will be released into a city, wherever you*

like, with a permanent residency visa, then you can travel everywhere, even you will be allowed to travel to Iran to visit your family' ... I thought 'wow, it is great'. (Fariba, 35)

In contrast to this ideal scenario, the participants were informed in detention that they would not be granted Australian permanent residency. After release into the community, the participants faced the reality of living in a new environment without secure residency. At the time of the interviews, it was between two and three years since they had lodged their refugee applications, and still they awaited a decision.

Living with insecure residency was described as 'a pending condition' and 'limbo' in which the participants were neither certain about their current living condition nor the future.

Pending. We are in a status like a limbo now. We don't know what will happen. Pending is very bad. (Ava, 32)

Analysis of the narratives apportioned a large part of adverse psychological and socio-economic outcomes to living with this uncertain residency status.

6.3.1.1 Feelings evoked as a result of living with insecure residency status

Almost all participants in this study were receiving counselling services at the time of the interviews. Regardless of their reason for migration, the participants perceived their insecure residency over the preceding two to three years as being very stressful. The prolonged and constant stress increased the risk of psychological disorders in the participants. Fear, hopelessness, and confusion were feelings that emerged from narratives about living with insecure residency.

Feelings of hopelessness and fear of being deported back to Iran brought a great deal of stress and threatened the participants' mental health. One participant believed that

deportation would exclude her from society in Iran, leading to psychological distress, hopelessness, and inability to maintain a normal social and emotional life. The excerpt below reflects the psychological distress associated with the fear of deportation.

> *[If I get deported to Iran] I will not be able to live a normal life. I will be a worthless person … my life will be destroyed … If we have to return [to Iran] or go back to the camps we will suffer from mental and psychological problems. It is horrifying … This [returning to Iran] would be a failure to me … Like losing my loved one, because it'll ruin my whole future. (Shiva, 30)*

Comparing the scale of suffering to grieving for a loved one reflects the adverse effect of fear of deportation that resulted from not knowing if she would be allowed to stay. This severe fear and hopelessness may relate to her past social status as a divorced woman in a patriarchal society where she had no hope of rebuilding a peaceful and nourishing life.

In addition to the fear of deportation, two participants reported that they had been told they may be moved to another country. This uncertainty affected the participant's planning for the future. For example, a participant who intended to have a child in Australia stated that she received frequent calls from immigration officers informing her of the plan to transfer her to a place out of Australia. Although it never happened, the participant suffered two abortions because of fear of having to raise her child in an under-resourced country, decisions that resulted in further health complications for her later.

> *I aborted my foetus because immigration officers would call me at least once per week and tell me 'you are supposed to be sent to Nauru' … My stress was triggered. So, I aborted my child … I became pregnant for the second time. Again, I was called by the immigration [department] and told 'you will be sent to Nauru'. I aborted my child again …the abortions resulted in uterus adhesion and miscarriage … I decided to have a baby last year, but had a miscarriage. (Neda, 32)*

Apart from the lasting physical complications, the repeated abortions created a sense of guilt in the participant, disturbing her mental health. As a Muslim, abortion was against her religious beliefs and regarded as an unforgivable sin.

> *I am Muslim and this [abortion] is really bad for me. But they [immigration officers] created a kind of psychological warfare that resulted in the action inconsistent with my beliefs… Once my daughter told me 'please don't take the baby off your tummy next time mum'. This annoys my husband and me. We are sinners … I worry about my daughter because she will be alone in Australia if one day something happens to me or my husband. (Neda, 32)*

Since she was never transferred out of Australia, she believed the Australian Government was attempting to bully her with the threatening calls over the preceding three years. Although the intimidating calls discontinued eventually, the multiple abortions led to serious physical complications and caused profound psychological disturbance and self-blame in the participant, resulting in the need for prolonged mental healthcare.

The prolonged visa processing time, moreover, confused participants about their current and future life conditions in Australia. One participant had English language skills that could secure her a job and income, but confusion through living in limbo contributed to a sense of hopelessness and worthlessness as an asylum seeker in Australia. Being divorced and having no children might have added to her stress of loneliness and hopelessness about the future.

> *Future!! What future? The future that I am not sure about. Look, I am not important here [in Australia]. I don't care if I die tomorrow. What will change if I won't be [alive] tomorrow? I have no hope for future. Nothing. I am just waiting for my life be over and die. That's it.(Shadi, 29)*

In addition, the lack of secure residency hindered some participants from pursuing their aspirations. One, who was formerly a full-time English teacher in Iran, explained how being labelled as an asylum seeker and lacking secure residency made her despair over rebuilding a life and future in Australia.

> *The first thing [that] demotivated me was the fact that I was an asylum seeker here … It means I had no work permission. What could I do? For me, who used to work from morning to night in Iran, it was hard to accept I cannot do anything [here] … should I stay at home? What should I do at home? I was like mad persons on the first days [after release into the community]. I kept going to the library, attending various classes … One day, I asked [myself] why I am doing these? … I am not supposed to stay here … I gave up. (Nasrin, 35)*

She tried many ways to regain her identity as a productive individual in the new society, such as voluntarily teaching English to asylum seekers. However, after a while she felt disappointed when she realised that her insecure residency would prevent her from gaining a paid job. Giving up her efforts, hope, and social involvement, while she had no language barriers, resulted in isolation and mental health issues that placed her in need of regular counselling services.

Lack of hope of reuniting with family members left behind in their country of origin was another adverse outcome of insecure residency status. The majority of participants (n = 12) wished to visit their family members in their home country or a neighbouring country; however, their insecure residency did not permit them to reunite with their family for an indeterminate time.

> *I would just like to visit my parents. Just this. This is the only thing that I think about all the time. I need a refugee visa [to travel outside Australia] … If I*

had one member of my family here, I wouldn't think about going back [to Iran]. I am alone here. I feel homesick. (Zahra, 27)

Lack of hope of reuniting with family members also resulted in marital relationship breakdown. One participant's partner had planned to bring his teenage son and mother to Australia soon after release from detention; however, he was informed about the current reunification policy on boat arrivals that prevented asylum seekers from bringing their family to Australia. Feeling responsible for his son and mother, who were left unsupported in Iran, he decided to return to Iran to take care of them while his partner, the participant, decided to stay in Australia. The forced separation added to the participant's mental distress.

My partner thought we would remain in this condition [insecure residency] for ever. We would never get a permanent visa. He couldn't bring his son and mother here. We were told 'you cannot bring anybody here [to Australia]. Your condition is this, you will be in this condition forever. You'll never get a permanent visa'. He was scared … So, he thought he had to return although he didn't like to go back at all. (Nasrin, 35)

Although the interview was conducted one year after her partner had returned to Iran, recalling the memories made this participant emotional. Interestingly, she did not blame her partner for his decision, because she believed that a sense of responsibility towards his family forced him to return to Iran. Instead, she blamed the insecure residency and the reunification limitation for asylum seekers for the relationship breakdown, the consequent emotional suffering, and her need for ongoing psychological counselling.

In general, fear of deportation, confusion, and hopelessness were evoked as a result of living with insecure residency and threatened the participants' psychological wellbeing. Despite receiving psychological treatment over the years of living in Australia, nearly all

participants continued to suffer from mental health issues. The excerpt below illustrates that insecure residency contributed to neutralising the effectiveness of psychological treatment and counselling services. She had left her secure job in Iran to gain freedom and reach peace and stability in Australia, although she had little hope to achieve her life goals while her residency status was insecure.

> *I saw a psychologist for two months … I didn't like to go out, I would stay in my room and keep thinking, thinking, thinking … I went to a psychologist for six sessions and then further six sessions. Then, fortunately, I got better. I was well for one year. Again, I got depression because I had no [permanent] visa to feel relieved. (Roya, 34)*

6.3.1.2 Socio-economic ramifications of living with insecure residency status

The long period of instability and indeterminate future hampered the participants' socio-economic settlement. It deprived them from gaining the necessary resources to meet their needs including study, employment, housing, and health. Having secure residency could enable the participants to enter the education system as domestic students without having to pay high tuition fees as international students.

> *Apart from my insecure residency condition, I don't really have any other concern … My problem is visa [permanent visa]. If I get my visa, I will get permission to study. If I have a permanent visa, I can do everything I decide. But we can't do anything at this stage [with no permanent visa]. (Elena, 28)*

This participant, similar to some others, believed that studying in the Australian education system would give her the opportunity to have a secure job and income. They could not make this dream come true without having their refugee applications approved. Another participant expressed her concern about the risk of losing her job following expiration of

her current bridging visa. She was separated from her partner at the time of the interview, and the stress of affording the living expenditures by herself added to her concerns.

> *Will I get a permanent visa or not?... I rather not to think about it, but I can't avoid thinking as my current visa will expire by the end of the year. What should I do if I don't get work permission to allow me work at school or the language institute?. (Nasrin, 35)*

Both participants above shared their deep concern about their insecure residency that impaired their ability to regain their socioeconomic position in Australia. In some cases, inability of successful socio-economic settlement and regaining lost previously held high social positions resulted in impaired family interactions and breakdown in family relationships.

> *He [my husband] went to a university and told 'I am a lawyer and I want to study'. He had to pay for the university [as an international student] and the government didn't cover it. So he couldn't afford it … My husband was under pressure … he didn't have a job. There were some jobs that he couldn't do. He just studied [in Iran] and couldn't do cleaning or masonry jobs. They were not fit to his character. Lack of money was annoying us … I found a job in a hair salon … My husband wasn't happy and his stress worsened. He would stay at home and smoke water pipe … He was getting totally mad. He couldn't gain money. He would pick on me. (Sima, 39)*

The insecure residency and resultant deprivation from study and work made this participant's husband feel that his breadwinner role was shaken. His past upper-class occupation in Iran made it hard to cope with the new situation. The resultant sense of uselessness and powerlessness along with the cultural belief that considers men as the main family breadwinners, described in Section 6.3.2, resulted in family conflicts and

eventually divorce. For this participant, the divorce led to the tragedy of losing her children and consequent mental health issues.

> *I got crazy the night my children went back to Iran … How did I let my daughter go?... I became depressed, I would walk the streets crying. I would go to my daughter's school and sit there and cry. I became crazy, would beat myself, blame myself, and mess up my room, scream, break all my stuff. (Sima, 39)*

Apart from marital conflicts, children required suitable living conditions. The inability of parents to fulfil their children's needs contributed to a range of conflicts between parents and children. For children, who used to live a relatively comfortable life in Iran, loss of financial resources was perceived as a stressful experience. Moreover, they did not completely understand their residency status and limitations on asylum seekers in Australia. The excerpt below shows a participant's concern about her relationship with her children.

> *There is a big gap between us [family members] … Difficulties, our financial condition. Many people are working without work permission … My daughter cannot understand that we don't have a permission to work. She says 'many people don't have work permission but they are working. Why don't you work?' This has damaged our relationship … My children like to eat in restaurant. I have taken them to a restaurant only once over the last two years. They want to go to the park, but I can't afford. (Paria, 40)*

The important point of the statement above, which was also experienced by other participants, was their inability to explain their situation to their children. This participant scaled her economic status as excellent in Iran. Like other three participants, while she fled Iran to save their lives, her children perceived the change as a means to a more

comfortable life in the new country instead of seclusion and deprivation from their basic needs.

With respect to the financial ramifications attached to the lack of secure residency and employment, some participants' health needs remained unmet. At the time of the interviews, all but one participant (who remained in community detention) held bridging visas and had Medicare cards, which enabled them free access to primary healthcare services, such as general practitioners, maternity care, and counselling services. However, referrals to specialists and dentists were not fully covered by Medicare. Therefore, individuals with financial restrictions had limited access to such services. A participant who was suffering from a chronic disease, arthritis, believed that she would receive more appropriate treatment if she could afford specialist care. However, her insecure residency prevented her from working, which made it almost impossible to afford a specialist visit. Lack of ability to afford specialist services delayed seeking treatment for her illness, which worsened over time.

> *The specialist told me 'I can't visit you more than three times because it is not free'. If I go to the specialist, I should pay $70 and my caseworker pays the remaining $30. You know, they [health providers] don't care about me. My depression is due to this … I have many problems. Now, I have toothache, but my caseworker doesn't refer me to a dentist. If I go [without a referral letter] I should pay [out of pocket] … If I need a sonography or physiotherapy, I should go to emergency unit or I should register in a waiting list and it will take several months to make an appointment for me. (Shery, 40)*

In addition, renting a suitable property was hampered by lacking secure employment, financial credit, and most importantly, secure residency. Difficulties with housing were reported by more than half of the participants, who found renting a home as their first

challenge in their settlement. All participants had been provided with temporary social housing for six weeks upon their release into the community to enable them to find a rental accommodation. Despite having a relatively adequate time to rent a property, they faced several barriers. First, they found that real estate agents and homeowners were often reluctant to rent a property to someone who was an asylum seeker. Not having secure residency and the related issues including lack of employment, financial limitations, and the stigma attached to asylum seekers were obstacles to renting a home. The following excerpt shows the impact of insecure residency on a participant's experience of housing.

> *Housing was my big problem. They [real estate agents] didn't rent us [asylum seekers] a home easily. It was a lot of trouble to rent a home …We had to inspect accommodations in various suburbs and we could only inspect homes one day a week … For different reasons; they didn't want to rent us. [For example] 'You are being paid by Centrelink, you don't work, and you have no credit'. (Roya, 34)*

As a whole, insecure residency and its consequences were the main obstacles in obtaining housing. Other barriers included limited and inflexible inspection times, unfamiliarity with different suburbs, lack of a private car and relying on public transportation to reach property inspections on time. Interestingly, regardless of their socio-economic status in Iran, which could affect their expectations of housing and living conditions in Australia all participants shared similar experiences regarding renting a home in the new society.

In addition, the participants were critical of the system for not providing asylum seekers with essential information about the housing market and the renting rules in Australia, which in some cases resulted in extra financial burden.

I didn't know anything about renting a home, like I have to give notice [for moving out] three weeks earlier. How would I know that? I ended up paying for two rents. (Soraya, 29)

Stress over renting a home eventually compelled one participant to bribe a real estate agent to help with finding an affordable accommodation. This was a shocking experience as she did not expect to have to bribe to rent a property as a basic need. She blamed insecure residency that stigmatised her as a vulnerable person, unable to afford renting a property. This damaged her self-esteem, and hindered her sense of belonging to the host society because she developed a perception that only asylum seekers had to commit illegal acts to meet their basic daily needs in Australia.

We were asylum seekers, not even refugees. We had no jobs, no reference, and no help in finding a home. My caseworkers have not been helpful so far. Eventually, a friend advised us to give bribe to a real estate agent to find us a home. We had to give bribe to a real estate to rent a home. (Nasrin, 35)

Sharing a home was a strategy that six participants used to overcome their housing difficulties, however, they found it difficult to adjust to sharing their belongings and privacy with others, which at times led to conflicts, arguments, and mental distress.

I couldn't rent a home. My friends called me and said 'you can live with us till you rent a home'. I lived five to six months with my friends. I wasn't alone and it was good. However, I wasn't comfortable there. I paid my expenses but I didn't feel comfort. (Roya, 34)

While sharing a home relieved housing difficulties in the first months of living in the community, this participant wished to regain her privacy, which she lost as a result of migration. Leaving a relatively comfortable life in Iran, where she was financially able to

live in a private home, made it difficult for the participant to share her living space with others for a long period of time.

While two participants perceived it easier to rent their second home, other participants were still experiencing difficulties in affording a convenient home at the time of the interviews. Despite having a reference letter and knowing the Australian housing market, affording a rental home was a persistent problem for most asylum seekers. While financial limitations affect many Australian residents' ability to rent a home in a desirable area, it was more serious for asylum seekers.

> *We can't rent a home everywhere [we like]. Why all asylum seekers live in this area? Because they don't have enough money. We like to live in good suburbs indeed [but we cannot]. When you live here, who are your neighbours? Arabs, Iranians and Afghans. You have to communicate with them. So, you can't find some friends who talk English very well. (Soraya, 29)*

The participant perceived living in dominantly non-English speaking suburbs as a barrier to integration of asylum seekers into the Australian society. Since her insecure residency and the resulting economic limitation forced her to live in suburbs that were occupied mostly by new arrivals and non-English speaker immigrants, she perceived it as difficult to pick up on the host society's language and culture. This hindered her sense of belonging, integration, and incorporation into Australian society.

In general, socio-economic problems were linked to the participants' insecure residency. The participants believed that if they had a permanent refugee visa, they would have had fewer problems in meeting their needs.

6.3.1.3 Social exclusion

Ten participants believed that their current insecure residency status excluded them from society. They cited their perception of stigma and discriminatory behaviours and communication barriers as two main reasons for exclusion, which resulted in their social isolation and mental distress.

Participants discussed the perception of discrimination in relation to being an asylum seeker and Muslim. This was described as a negative experience that increased the risk of social isolation and withdrawal in this population group. One participant articulated her experience of being stigmatised and excluded from Australian society due to her asylum seeker status, and Middle-Eastern appearance and background. The excerpt below shows the destructive psychological effects of discrimination and harassment on the participant as a victim.

> *My younger daughter and I have been harassed by some people. I didn't know what they were saying. Then I investigated and realised that they [words] were swear words … The most annoying feeling is that I feel [Australian] people here hate me and all other asylum seekers and refugees. I even don't like to get out of home. Generally, sense of being a burden … I feel that I am redundant. I feel that here is not my place. I don't have any place neither in my country nor here… I can see the hate in their [Australians'] eyes. This makes me feel burden. (Paria, 40)*

Participants also experienced stigma and racist behaviours within the education system. The above participant recounted her daughter's experience of racist behaviours at school. Although she was living in an area where the majority of the population were from culturally and linguistically diverse backgrounds, and accordingly many students at school were culturally and linguistically diverse, her daughter still experienced racist

behaviours from her peers. Her daughter was singled out for being an asylum seeker from a Middle-Eastern country and was excluded from social activities at school.

> *My daughter says that 'they [Australians] are very racist at my school. They don't talk with us [non-Australians], even one word'. (Paria, 40)*

This participant went on to explain that perceived racism at school could disturb her daughter's bonds and connections, excluding her from society. This participant was clearly concerned about her daughter's mental health being affected by the experience of racism and social exclusion at school.

Another participant described her experience of being bullied in public for being a Muslim. In this study, about 60% of participants (n = 10) were Muslim, but only one complied with the Islamic code of dressing and wearing scarf. She was also the only participant who perceived discrimination for her religion, more likely due to her choice of dress that identified her as a Muslim. However, she perceived the bullying behaviour as relating to an individual, rather than generalising it to the whole of Australian society.

> *I was in a shop a couple of days ago, a woman told me 'fuck off with your scarf'. She cursed to my scarf but I didn't respond because I know many Australian friends who have helped me. It wasn't important to me. Actually, good and bad people are everywhere. (Neda, 32)*

Her positive attitude towards Australian people developed through the assistance and empathy she received, helping her to overcome occasional prejudicial behaviours. Another participant described a similar experience of receiving respectful behaviours from Australians. She related this to the nature of living in a multicultural country and described that the overflow of immigrants to Australia protected them from discrimination, stigma, and racist behaviours from Australian people. From the

perspective of this participant, the large immigrant population has compelled Australians to accept new arrivals.

> *They [Australians] are not racist because [the] immigrant population is dominant here. I have seen racism here but very few. It wasn't annoying. Here is not like Europe because there are many immigrants here. Veiled women, Muslims are living here next to others. All are similar to each other in terms of their rights. (Fariba, 35)*

Contrary to the previous participant, the woman above was Christian. Not wearing Islamic dressing might have protected her from perception of stigma and racial behaviours.

The shame of being labelled as 'asylum seeker' and 'boat people' by others, including Australian people and other Iranian immigrants, created anxiety over being judged and stigmatised in some of the participants. As a result, one participant intentionally isolated herself from both Australian people and the Iranian community in Australia due to her sense of shame regarding her method of migration (i.e. boat arrival). Due to the fear of being asked about her residency status in Australia, she withdrew herself from society, avoiding social gatherings and activities to reduce her tension.

> *I am always anxious about being asked how I came here … What is your visa type? … I feel they will misjudge me. This is a source of anxiety for me … This [coming to Australia by boat] is a big shame with me forever … I was invited to my friend's wedding. I felt that the groom didn't like his parents to know that I have come by boat [to Australia] … I felt that they [my friend and her husband] were ashamed of it. This annoys me … In the wedding party, the groom's friends liked to talk to me, but I was anxious about being asked about my visa … So, I made an excuse and cut the conversation. (Nasrin, 35)*

The fear of being stigmatised as a 'low class' immigrant led to her withdrawal from socialising. Although working as a bilingual assistant at a school obliged her to interconnect with a range of people, she was reluctant to expand her relationships beyond work.

Apart from the stigma attached to asylum seekers that excluded them from society, most participants experienced social exclusion due to their poor English language skills. A lack of ability to communicate within the new environment was cited as a factor that prevented the participants from obtaining necessary information about living conditions in Australia. Poor English language was raised as the most common barrier preventing the participants' interaction with the local community. Learning about Australian socio-cultural norms and values was believed to be achievable through constant communication with Australian people. Accessing television, radio, and the internet was also assumed as a pragmatic way of becoming familiar with Australian socio-cultural norms; however, due to language barriers, this context had limited benefits for most participants in this study. While some participants were willing to improve their English language skills to become useful community members, and regain their self-esteem, many barriers impeded their English language acquisition. Adverse post-migration experiences, such as living with insecure residency status and its consequences, such as family conflicts and psychological concerns, reduced some participants' motivation and capacity to acquire new skills. For example, a participant who had experienced separation from her husband and was left alone in her new environment described her inability to concentrate on English language studies. Struggling with daily post-migration challenges and taking sole responsibility for her child as a single mother impeded her English language acquisition.

> *I can't concentrate on learning English. I like to learn but I can't. I am tired, distressed, what will happen if I can't get a permanent visa … I came here, imagine, a woman with a little girl in a new country! … I got divorced and had to manage my life all alone. (Zahra, 27)*

Trapped in a vicious circle impeded most participants' successful settlement, excluded them from the host society, and negatively impacted their mental health. The participant above discussed the impact poor English language had on developing her social life. She asserted that the poor interaction resulted in withdrawal from society and a feeling of social isolation.

> *I didn't know English. The first days after coming to Sydney was very difficult. Think, I couldn't learn how to catch a train, how to work with [google] map, I would inspect properties [for rent] but I didn't know how to complete the forms. The new environment was strange. I felt myself separated from people. (Zahra, 27)*

In addition, one participants experienced social disadvantages because of inability to express their views and advocate their rights, which was another source of stress. She highlighted her poor English language skills as a reason for being stigmatised and mistreated in society. She shared her experience of being suspected as a shoplifter and her lack of ability to defend herself due to poor English.

> *I was shopping … I spent over $50. I had two leftover biscuits in my bag. They [cashier] asked me 'what is this? Where is your receipt?' … I felt very bad … I couldn't explain to her. She knew that I couldn't speak English … This is the worst thing when you are right but you can't advocate your right just because of your language. (Soraya, 29)*

While this can be an example of discrimination, this participant blamed her poor language skills for not defending herself. Due to cultural and language barriers she might not have

perceived and/or reported discriminatory behaviours. Her lack of ability to safeguard against misjudgements, mistreatments, and discriminatory behaviours due to language barriers seemed to contribute to her reduced self-esteem and withdrawal from society in order to avoid similar adverse experiences and related distress.

Poor English language, moreover, reduced the participants' confidence in communicating with local people who could help ease their resettlement in the new society. Trapped in this vicious cycle, the participants missed opportunities to improve their language skills via interaction with English speakers due to low self-confidence. Clearly, a lack of communication and interaction due to poor English and low self-confidence excluded the newcomers from the host society.

> *I have no connection with Australians because of my English. My English is not very good and my self-confidence is low. So I get nervous. I go to church where all people speak English, but I don't talk to them. I have some Iranian friends there [in the church]. I ask my Iranian friends to help me whenever I don't understand [what the Australians say]. (Roya, 34)*

This participant who used to be employed and had a broad social networking in Iran had an intention to communicate with Australian people; however, her low self-confidence prevented her from being involved in verbal communication. Moreover, having some friends to assist with her post-migration settlement, she lost her motivation to learn English and involve herself actively in the host society. Low confidence in communicating with English speakers made this participant dependent on the Iranian community, which further hindered her integration into the host society.

Due to their insecure residency, some participants were reluctant to learn English. To minimise their need for communication with English speakers, they colonised in areas

populated predominantly with Iranian people. Although spatial exclusion enabled most participants to meet their daily needs, such as shopping from Iranian stores and working with a minimum need to speak English, it isolated them from Australian culture and society, which added to their mental distress. The excerpt below demonstrates the impact of the language barrier on immigrants' integration into their surrounding environment.

> *One of my problems is English [proficiency]. You will realise in your research that the majority of Iranians here are suffering from the inability to communicate verbally. Because we are like a baby that cannot speak. I cannot speak with them [Australians] ... The environment is totally Iranian in Merrylands [the suburb where she was living]. My workplace is also Iranian ... In particular, when you come to Merrylands you feel that you are in Iran. I have to see the Iranian shops every day. (Fariba, 35)*

6.3.2 Living with cultural incongruity

The participants expressed mixed opinions about Australian culture and lifestyle. While some participants appreciated the host society's culture, most participants perceived it as not being in harmony with their cultural values and they described it as a shock to face the new culture. Participants also shared their experiences about how the new culture influenced different aspects of their lives, from family relationships to mental health and wellbeing. The section below presents the participants' views and attitudes towards Australian culture, and the impact of being exposed to a second culture on their life circumstances and psychological wellbeing.

More than half of the participants (53%) were grateful for being dignified, supported, and valued as a woman in Australia. They claimed while their needs and human rights were often overlooked as women in their country of origin, the extent of support and respect they received in Australia was beyond their expectations. They believed that the strong

policies and legislation that are rooted in the dominant culture support women's rights and gender equality in Australia and allow women to be aware of their rights, advocate for their rights, and meet their needs appropriately. One participant articulated the difference in attitudes towards women and women's rights between Australia and Iran.

> *Here [in Australia] men cannot violate women's personal rights. If you choose to live a peaceful life, you can. Nobody has the right to interfere in your life. A man cannot force you to do something you don't like. But in Iran men have the right to determine what a woman must or must not do. Here is not like that. This means equal rights. As a woman I have a nice feeling here, but I was treated like an object in Iran. (Shiva, 30)*

The above participant was a divorced women and the victim of the patriarchal culture in Iran where her human and maternal rights remained overlooked and were trampled on. She expected to be treated as a respected person in Australia, and she found Australian legislation and culture supported that expectation.

Enjoying a respectful and supportive environment in Australia resulted in the women reconsidering their rights and position within their family and society, a transition that was often not welcomed by their husbands who were inclined to preserve their original male-dominant culture. The resulting discrepancy between the women and their husbands' attitudes about the role of women within the family and society contributed to violent conflicts, resulting in divorce in two cases.

> *I told [him] 'I gonna work if you like it or not' ... My husband would fight me and say 'you are a degenerate woman. You think you are free here to do whatever you like?' ... I would fight back to advocate my rights ... My husband saw these and got totally mad. We would argue every day ... He would tell me 'you came to Australia and became disobedient. You think you will be supported by the government because you are a woman?' (Sima, 39)*

The above participant had been a housewife in Iran, and was not expected to extend her activities beyond the family boundaries or participate in social activities. However, coming to Australia increased her awareness about her rights to work and become an active member of society. Her husband, on the other hand, remained attached to the patriarchal culture and found it difficult to accept his wife's social activities and economic independence. In addition, the fact that both men and women work together in Australia did not match his cultural and religious values, and he regarded it as a threat to his authority.

> *I was wearing singlet at work. He couldn't tolerate it. He would say 'you are naked in front of other men' ... If he would see a man in the hair salon, he would suspect me. He would ask me 'who was that man in the salon?' I would keep telling him 'here is Australia. You can't ban men from coming into hair salons' ... I would talk to my caseworker and tell her 'I want to divorce my husband. I cannot live with him'. I was really tired ... I told her 'you should separate me right tonight'. She arranged a small unit for me that night and escorted me there. (Sima, 39)*

In contrast to her husband, this participant had adapted to the dominant culture of Australia. Her awareness of the supportive legislation for women in Australia motivated her to stand up for her rights. However, the consequent family discord resulted in family breakdown and the return of her husband and children to Iran while she stayed in Australia. Although she benefitted from the increased freedom and support she received in the Australian context, she ultimately suffered family breakdown and loss.

With respect to facing the new culture, four participants acknowledged that marital relationships could more easily break down in Australia due to equal gender rights, resulting in wives' disobedience of their husbands. While men were willing to retain the patriarchal aspect of their original culture, the women tended to assimilate into the

Australian culture with its equal rights and a sense of dignity and freedom. The statement below reflects the paradox in a participant's feelings and her perspective about the changes that occurred within her marital relationship due to her arguments for equal gender rights. Despite problems in her marital relationship, she was still grateful for the extent of support and confidence she attained in Australia.

> *The men and women roles have changed here. Men [Iranian men] have realised that they may lose their wives easily. I am revenging him [my husband] for all the hard times he gave to me in Iran. In fact, my relationship [with my husband] has weakened because I behave how I like and he can't complain. (Ava, 32)*

Another participant appreciated Australia as a country in which women are protected and their human rights are supported regardless of their marital status. She related this support to the dominant Australian culture in which women are prioritised when rights, health, and social position come into consideration. She perceived the support as reflecting a priority for women rather than equality of genders. Using the word 'priority' can be related to this participant's experience in Iran. She articulated her difficult life after divorce, when her basic needs and rights were denied as a result of patriarchal attitudes that treat women as second-class citizens, meaning that women are dependent on men for their daily needs.

> *Women are important here ... This gives them self-confidence. Priority of women gives me self-confidence .... If you are not married, the government supports you. If I was in Iran now [in this situation] I couldn't work ... [without any support from the government]. It is very good that the government supports women here. A divorced woman is not hungry, depressed, homeless, and is not different from married women [in Australia]. This is very important. This is the important difference between here and Iran. (Shery, 40)*

Reviewing socio-demographic characteristics of the above participants showed a various spectrum of women who, interestingly, had the same positive perspective about the culture in Australia. They believed that support for women rooted in the Australian culture, which was appreciated by these participants.

Unlike the above participants, one expressed her concern about the impact of equal gender rights on marital relationships in Australia. She believed that support for women should be limited. Her personal experience might be the reason for her opposing opinion. She related her brother's experience of marital breakdown upon his arrival in Australia, and blamed the Australian system for providing women with excessive support as the motivation for her brother's wife to divorce.

> *Women are supported here, but it is false. For example, if you are a single mum you will be paid more money … Supporting of women should be limited. Aren't men human? Support is good when you are oppressed … From my point of view, the support for women is too high [in Australia]. If I am oppressed, I like to be supported, but some women misuse it. (Neda, 32)*

Without her personal experience, she might have perceived the equal gender rights and support for women as a positive aspect of the Australian culture.

Apart from the influence of acculturation on marital relationships, three participants expressed concern about their children adopting some negative aspects of the dominant culture in Australia, perceiving it as a threat to their children's future. The women were concerned that their children were already inclined towards the dominant Australian culture and had lost their cultural identity. They believed in success for their children through following their original culture that could lead them to a secure and successful future in Australia.

[In Iran] I was pregnant and concerned about my child's future … I came to Australia because I didn't like her to go through the same experiences as me and my sisters … If your child is a good child and you nurture them according to your own [Iranian] culture, they will have a bright future [in Australia]. If you can nurture them according to your own culture and show them what is good, what is bad, I think they will have a good future … but we don't accept the Australian culture at all. For example, children are very free after 18 years of age. I am very worried for my child. These things annoy me. She [my child] is a girl. I am worried if she dates boys at school. (Ana, 37)

Although the above participant came to Australia due to her concern about raising her daughter in the patriarchal culture in Iran, she was still bound to the Iranian culture and wished her child to retain her traditional culture. It seems that growing up in the patriarchal culture, although not appreciated, left traces of male gender supremacy in this participant's mind. As a result, her child's gender distressed her, as she believed in the vulnerability of girls. She might not have had such concerns if her child was a boy.

Similarly, another participant expressed concerns about her two teenage daughters resembling Australian teenagers. Although her life circumstance was remarkably affected by the patriarchal culture, she expected her daughters to follow their traditional culture and values.

I had a very nasty and crazy father … He broke my both hands … I wasn't normal [mentally] due to having these tensions. I was in trouble while growing up. I was not allowed to complete high school. When I got older, my father wished to get rid of me because I was a girl. I was affronted because of being a girl … but I am very worried for my daughters' future in Australia … We've got our own culture. When I compare it [our culture] to here [Australian culture], I find it [Iranian culture] better … I am worried that my daughters will behave like them [Australian children]. For example, children [in Australia] don't study, do tattoos. They don't like to talk to elderlies at

> *all. I like my daughters to be polite like in our culture. I like them to respect older people. I don't like the Australian culture at all … Generally, I am very concerned about my daughters to be like these [Australian] children. I don't like the Australian culture. (Paria, 40)*

Similar to the previous participant, this participant referred to her children's gender as her main concern. Growing up in a patriarchal culture likely affected her attitude and expectations that girls have to be modest. Although she did not explicitly talk about expectations of girls or boys, her emphasis on 'daughters' rather than 'children' created the sense that she might not have had the same concerns and expectations of her children if they were boys. This reflects evidence of carrying cultural baggage dominated by patriarchal attitudes.

Contrary to the above participants, one stated her strong intention to nurture her children in the same way as Australians. From her point of view, peace and calmness were ingrained in Australian culture, but was lacking in Iranian culture. She believed that by adapting to Australian lifestyle and culture, Iranian parents could create a peaceful and soothing atmosphere for their children.

> *We should change our behaviour, should avoid those things that do not bring peace to our life. For example, I like my children to be like them [Australian], relax. They [Australians] put a six-month-old child on the grass without any fear. They are relaxed. I like my children to be successful, especially my son who suffered a lot [during the transit]. I asked the psychologist 'what should I do for my children to be like these children?' We try our best but we don't have a peace of mind. What do they do to have calmness? (Mahsa, 31)*

This participant and her children had endured a very stressful period pre-migration and during transit to Australia, and their psychological health was affected by the hardships. Due to her stricken conscience for the difficulties her children endured during the transit

period, she wanted them to enjoy a peaceful life in Australia so they could recover from their mental health problems. Since she related all peaceful behaviours and calmness of Australians to their culture, she wished to follow the Australian culture and lifestyle to bring peace and happiness to her family.

6.3.3 Utilising healthcare services

This study aimed to explore Iranian asylum seeker women's health and contributing factors that affected their health-seeking behaviours. The participants in this study revealed their experiences of utilising healthcare services in Australia. Different experiences, as demonstrated in this section, affected their wellbeing. While most participants expressed their gratitude for healthcare services in Australia, some (n = 5) reported the constraints and difficulties they encountered using the services. Participants shared their positive and challenging experiences of interacting with healthcare providers and meeting their health needs.

Participants in this study shared mixed experiences of using healthcare services. While some appreciated the quality of care and services they received, others perceived their health needs as unmet. Apart from financial restrictions that hampered some participants' use of healthcare services, as detailed earlier as an economic ramification of living with insecure residency, some believed that healthcare providers, including doctors, nurses, and medical administrators, delayed timely access to appropriate care. One participant shared her experience of missing her appointment with a psychologist. Regardless of her urgent need for counselling, she was scheduled for a later date. She blamed the psychologist for overlooking her deteriorating mental health and delaying her treatment.

> *Once, I saw a psychologist. I talked to her and she made an appointment for a month later. But I missed that because of my memory loss. When I called her for another appointment, she told me that she was fully booked. So, she made another appointment for two months later. But I needed to see the counsellor very soon … My access to doctor and psychologist is very poor. They don't care about me. (Shery, 40)*

It seems that lack of knowledge about the high demand for mental health services in the public sector resulted in misunderstanding, which further led to a feeling of being ignored by the counsellor that increased this participant's dissatisfaction with the services. In addition, another participant shared her experience of not receiving timely care in an emergency department when her partner was severely ill.

> *My boyfriend was unwell … I took him to a medical centre. The GP said 'he must be transferred to a hospital by ambulance otherwise he would develop stroke'. We were taken to Westmead Hospital by an ambulance but he wasn't examined for a long time. So, he said let's go back home. All in all, I am not satisfied. (Nasrin, 35)*

This participant said that her partner was left with no explanation about the process of medical examination in the emergency ward at the hospital. As a result, he was frustrated by being left unaware of his circumstance and the length of the medical process in the emergency ward. The frustration contributed to leaving the hospital without receiving treatment for his condition.

Another participant, similarly, shared her experience of not receiving information about the consequences of frequent abortions, which contributed to later physical health issues. This participant linked the lack of provision of information to the doctor's discriminatory behaviours against asylum seekers.

> *I asked several doctors about the reason for my miscarriage. All replied 'we don't know' … Nobody helps us here to reach our goals. They keep us [asylum seekers] from reaching our goals … I read somewhere that abortion could result in uterus adhesion and miscarriage. Nobody [no doctors] told me about that. (Neda, 32)*

Three participants in this study depicted a politicised healthcare system in Australia. They believed that healthcare providers discriminated against them intentionally to comply with the current immigration policies against asylum seekers. Along this line, one participant shared her experience of being neglected with regard to her physical problems as a result of the doctor's attitude towards asylum seekers as vulnerable people that could not afford their healthcare costs.

> *I was pregnant, my nausea got worse due to cold weather in winter. When I was in the camp, I was taking an anti-nausea tablet that was very effective. I asked the doctor to prescribe it for me [in Sydney]. Doctor told me 'you cannot afford it. It is expensive'. She didn't prescribe it. I was upset and felt that I was discriminated. My vomiting worsened and I couldn't bear it. So, I decided to abort my child. (Paria, 40)*

Being refused regarding her request for an expensive medication was perceived as discriminatory behaviour. However, the refusal might be related to the doctor's attitude of improving patient health with more affordable medications and health advice. This is a controversial point about healthcare services that emerged in this study that should be discussed.

Poor interaction with healthcare providers was another negative experience that emerged from the narratives in this study. One participant perceived that she was being overlooked and disregarded by the doctor. While she had the view that a thorough consideration of her lifestyle, such as diet and exercise, would contribute to a more accurate diagnosis, the

doctor asked only for a short description of physical symptoms to make a diagnosis. As a result of the lack of an effective interaction with the doctor and resulting lack of trust of his diagnosis, the participant failed to adhere to the treatment regimen.

> *The specialist doesn't answer my questions. He doesn't give me any advice. No exercise, no special diet, nothing … He is a good doctor, but I think he doesn't know my real problem. [I think that] he has grown up here, so doesn't understand my problems [that I tolerated before immigration]. He only emphasises taking medications … I tell him let me talk and explain [my problem] but he ignores. (Shery, 40)*

This poor doctor-patient interaction was also experienced when the participants used mental health services. Participants in this study were generally identified as a vulnerable population who were at risk of poor psychological health. Experiencing traumatising events prior to migration and during transit to Australia followed by experience of compulsory detention and ongoing insecure residency and instability over the years of living in Australia increased their need for counselling therapy. Despite ongoing utilisation of counselling services during the preceding two to three years, almost all participants were still suffering from mental health issues at the time of the interviews. Most participants attributed their recurrent or untreated mental health issues to living with insecure residency.

> *I met a psychologist for two months. I was distressed because I had no [permanent] visa. I was wondering what will happen. I didn't go anywhere, only in my room and think, think, think. My caseworker booked a psychologist for me. I went to a psychologist for 12 sessions. Then I got better for a while. It was temporary. After a few weeks, I again felt distress. I met the psychologist again. My visa problem has not been solved. So, how can I get rid of this stress? (Roya, 34)*

The participants also perceived poor interaction with mental health providers as a factor disturbing the effectiveness of the counselling services. They valued interactions where they felt comfortable asking questions of healthcare workers and receiving appropriate advice and empathy. However, most participants stated that they did not receive such interaction when they sought help from counsellors. They believed that the cultural and language gap hindered their communication with the counsellors. The excerpt below demonstrates a cross-cultural lack of understanding in using mental health services. As evident in this excerpt, the participant expected the mental health counsellor to listen to her story sympathetically and provide her with effective advice to help improve her mental health.

> *I am not satisfied at all because I feel that the psychologist was only a listener. She was a Lebanese and was born in Australia. I asked her to help me to tell my problems to a right person, she would tell me 'let me ask my boss'. I never received a response though. During the sessions, I was feeling that I was in an empty room and talking to myself while I was talking to the psychologist. I didn't have a nice feeling. Once I told her that 'I want to set fire on myself', but she only stared at me. (Paria, 40)*

The above participant believed that she was not able to interact effectively with the counsellor due to language and cultural barriers. In addition, using an interpreter, seemingly, not only did not facilitate communication, but also reduced the attention the participant expected to receive from the counsellor. According to the participant's opinion, the lack of cultural and language competency of the counsellor contributed to a failure in the treatment of her depression after three years of using the services.

Apart from negative experiences, two participants shared their positive experiences of using maternity care services that offered high-quality care and support during their pregnancies.

> *If I was late one day, they [midwives in maternity care] would call me to see why I missed my prenatal care [appointment] … After giving birth, I wished to stay at the hospital because I had no family to look after me [at home] … I was very happy in the hospital. They [midwives] looked after me very well. (Hale, 25)*

As an asylum seeker, she appreciated the support provided by the midwives in the maternity healthcare sector that helped her overcome the lack of family member support in Australia.

In general, using healthcare services emerged as a controversial subject in this study. While some participants were satisfied with the services, the majority shared negative experiences and health outcomes, in particular in mental health. However, the researcher interpreted some negative experiences as misunderstanding or lack of knowledge about the healthcare system in Australia. Chapter 8 discusses this discrepancy and compares it with other contexts.

Chapter 7: Results (3)

Building resilience

7.1 Introduction

The experiences of the participants during pre-migration, transit, and post-migration periods, and the impact of these experiences on their health outcomes, were presented in the previous chapters. Some participants described various degrees of psychological issues, ranging from minor mental distress to major depression, as a result of the endured difficulties. However, all participants attempted to develop strategies to adjust to their circumstances, enhance their resilience, and maintain their mental health. This chapter, as depicted in Figure 7.1, addresses the fourth research question "In what way do Iranian asylum seeker women increase their resilience towards migration-related difficulties?".

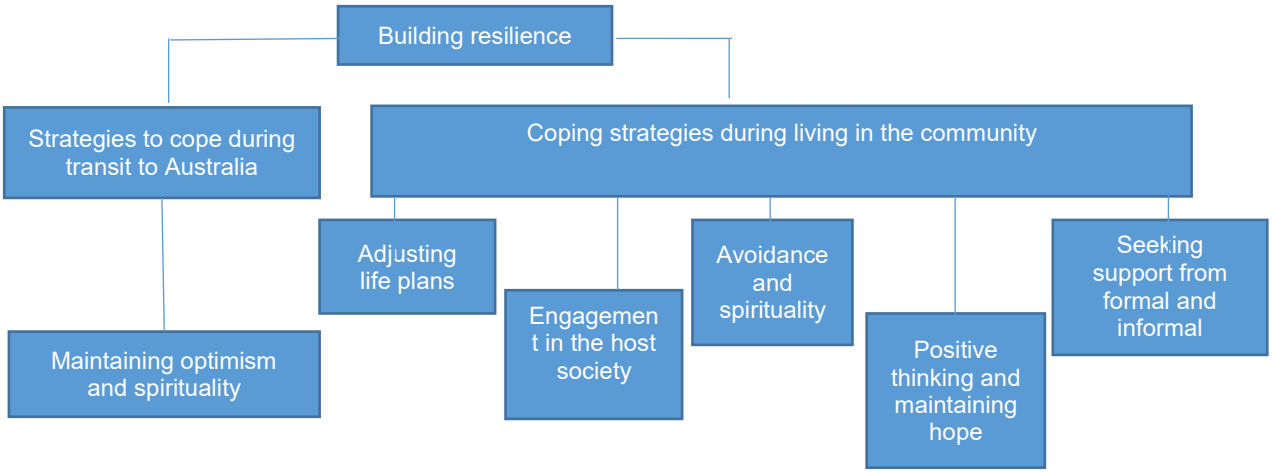

Figure 0.1: Coping strategies employed by participants

7.2 Coping strategies during transit to Australia

The women shared strategies about how they navigated challenging contexts during their journey and resettlement in Australia. During transit, the participants maintained their optimism about their future in Australia where they hoped their life would improve. This hope for the future helped them to cope with the difficulties of the journey.

> *Of course it [Indonesia] was very dirty but endurable for a short period. I didn't like it. I didn't have a good feeling in Indonesia. But it wasn't important for me because I knew that the situation was temporary … I liked to come to Australia very soon. (Shery, 40)*

Optimism reflected an emotion-focused strategy that did not change the stressful situation for the above participant, but helped her cope with the stressors. She coped with the sense of powerlessness in transit by holding to the belief that it would only be a temporary experience.

To cope with the difficulties during their journey on the boat, such as the fear of death, most participants used spirituality. These participants placed their trust in a higher power through praying and repeating religious words quietly to themselves. In a situation they felt powerless to change, the participants looked to their spirituality for strength. Most participants (n = 10) declared their religion as Islam, six were Christians, and one, although spiritual, did not identify with a particular religion. One participant, who was Muslim, recalled a dangerous situation on the boat, when all people prayed to God to save their lives.

> *The boat ran out of petrol and it stopped moving. Water came into the boat … The boat was getting heavier and we were going down … All people [on the boat] were praying. Even those who had been very happy during the*

journey started to read 'ziarate Ashoora, doaye tavassol' [Islamic prayers]. (Mahsa, 31)

Travelling on the perilous journey was associated with various difficulties that threatened the lives and health of the participants. However, contrary to several strategies that the participants developed and applied during the resettlement period, as described in the following section, few strategies were revealed from the transit experiences, more likely due to the short duration of the transit and resource limitations. Being powerless during transit, where the participants were under-resourced to protect themselves on one hand, and the temporariness of the transit on the other, meant nearly all participants sought help from a higher power. Maintaining their hope, optimism, and belief in a higher power that could save their lives while passing through the dangerous journey helped them reduce their stress and risk of lasting mental health problems.

7.3 Coping strategies during living in the community

Contrary to the transit period, where participants passively coped with the difficulties, they actively developed several coping strategies to deal with their challenges while living in the community to consolidate their strength to cope in the new society and maintain their health and wellbeing. As described in Chapter 5 and 6, the majority of participants experienced hardship during the process of migration; however, their mental health status and degree of integration into the host society varied. Participants presented their experiences of using various strategies to deal with difficulties that could hamper their resettlement and adversely affect their mental health.

Engagement with the host society, adjusting life plans, and seeking support from formal and informal resources were the main problem-focused and active strategies used. These strategies assisted the women overcome language barriers, acquire information about

Australian culture and society, and to feel like productive and valuable people. In enacting these strategies, the women reported reduced stress, increased happiness, and improved mental health. Emotion-focused strategies that helped the women adapt to their current circumstances included positive thinking and maintaining hope, avoiding difficult situations, and engaging with spirituality. Seeking support from informal resources through sharing experiences with friends and family members was also raised as an emotion-focused coping strategy. These strategies were useful particularly in situations where the women felt they could not control or change their circumstances.

7.3.1 Engagement with the host society

The participants actively attempted to engage in social activities to pursue their goals within the Australian context. Socialising through employment and engagement in social activities, and adapting to the norms of the mainstream culture emerged as the main problem-focused strategies employed by seven participants. Through socialising, the participants were able to tackle the constraints that delayed their integration into Australian culture and society. The women involved themselves in various social activities, depending on their skills, talents, and aspirations. They believed that being an active member in the new society enabled them to become familiar with Australian culture and lifestyle, and facilitated their integration and resettlement.

This study revealed language deficiency as a post-migration challenge that hindered more than half of participants from feeling they belonged to the host society, and isolated and excluded them from society. These participants explained that the government suspended free English programs for asylum seekers, and without a secure job and income, the women could not afford to pay for English courses to improve their communication skills. Four participants shared their experiences of being involved in voluntary jobs to help

improve their English language skills, become familiar with Australian culture, gain self-confidence, and help with their resettlement in the new society. These women possessed an academic qualification and were employed before migration. Coming from a higher social status seemed help with the application of problem-focused coping strategies, which in turn, facilitated regaining and maintaining their social status in the host society and enhancing their life quality.

> *I am socialised. Voluntary job, making connections with others give me self-confidence and elevates my spirit. So, I am hoping that everything will be ok … I have a good spirit right now because I could promote my status with voluntary job … I feel better than the first days after being released into the city. I am much better. I was really disappointed and pessimistic on the first days [after being released from the camp]. I've already changed. I am very hopeful. (Ava, 32)*

The work condition attached to asylum seekers' bridging visas was restricted; however, their circumstances varied case to case. The above participant lacked permission to work; however, her engagement in voluntary activities helped her feel connected to the host society and to gain new skills or reinforce existing skills that increased her hope for better employment opportunities and life in the future. This participant was also the woman who was traumatised due to witnessing her family member's death during transit. Socialising through a voluntary job helped her recover from the trauma of the transit, maintain her hope for building a better future in Australia, and cope with asylum-related challenges.

Another participant, who was similarly involved in volunteering, explained her reason for engagement in these activities as networking with immigrants from other countries. She believed that she needed to learn about various cultures and lifestyles to help her integrate into Australia's multicultural society. She had been volunteering in a multicultural centre

that served meals to charities. This type of social involvement not only improved her English communication skills, but also made her knowledgeable about the multicultural nature of Australian society and gave her a sense of pride as being a useful person in the host society.

> *There are some cooking classes and I teach voluntarily … It has helped me in terms of [learning] language. If I stay at home, I cannot practice English … This work has helped me to get out of the home. I got familiar with other people and cultures. Now I know how other people think about an immigrant. People from many countries come there [the charity organisation] … It [the job] elevates my spirit, so I don't think I am useless. I am working unpaid and the earned money goes to charity. So, I am helpful. I think they [Australians] have helped me, now I am helping them. (Neda, 32)*

The sense of being a useful member in the host society was the most valuable benefit of the voluntary work that made the participant feel content and satisfied with her living situation. Part of her motivation to volunteer was to reciprocate Australia for providing treatment to her daughter.

Another participant became involved in voluntary English teaching. Helping other asylum seekers from Iran to improve their English language skills gave this participant a sense of pride and confidence.

> *One day, I was asked to teach English in the Australian-Iranian Community Organisation. I love teaching. I accepted and I felt my life re-started. I was happy, I was teaching. The guys communicated with me easily. The elders, youths, those who wanted to rent a home would tell me 'we don't know what we should do'. I would help them because I had gone through those difficulties. [I would say to myself] I am doing something, so, I am alive. I would feel well mentally. (Nasrin, 35)*

This participant had been a teacher in Iran for 14 years prior to immigration to Australia. Without permission to get paid work due to her insecure residency, she found another way to enact her teaching role. As well as helping fellow immigrants, engagement in volunteer work helped her regain identity as a teacher.

Apart from boosting self-confidence, consolidating their identity, and improving their language skills, engagement in social activities – via paid or volunteer work – helped the participants gain information about the cultural norms and expectations in Australian society. Almost all participants in this study were released to the community without functional information to deal with their ongoing challenges. However, involvement in paid and voluntary work helped some participants gain necessary information about resettlement in the community, for example, transport, shopping, healthcare services, schools, and housing, which facilitated their resettlement.

> *I would think like I have to rent a home by myself and the money [that Centrelink used to give me] was not enough. I was also worried about living alone. But working helped me to get information about the Australian housing culture. I realised that I can share a room, I can share a home with a friend. I didn't know that. (Shadi, 29)*

As a problem-focused coping strategy, working provided this participant with the opportunity to obtain substantial information about the Australian lifestyle and culture via communicating with a broader range of people rather than only the Iranian community.

Engagement in employment, however, was perceived difficult for two participants, who had young kids with no childcare support. These women were desperate to improve their social engagement as their maternal duties limited their social involvement and activities

outside the home. To overcome this problem, the participants joined groups that offered free activities for mothers and children. This strategy helped them improve their English and overcome the constraints on socialising with the host society.

> *I go to gym every other day. I take my daughter to park, play groups and mothers' groups when I am free. These help me to socialise and talk to others and get familiar with different cultures. (Nazi, 34)*

Although engagement in employment and social activities helped the participants integrate with the host society and feel settled and connected, it increased some participants' stress by emphasising cultural and social differences. To feel accepted by the host society, avoid distress, and facilitate integration, some participants left their own cultural and religious beliefs to follow what was valued and dominant in the host society. The excerpt below is from a participant who converted her religious beliefs to feel connected to the host society.

> *I was grown up in a very conservative family. I didn't take off my scarf up till recently. I thought that it was a sin. I was a Muslim. After settling in Sydney, I started going to a church for English language classes. I liked those [Christian people]. I was fighting with myself for taking off my scarf. My father nurtured me as a Muslim, I had a sense of qualm. If I was supposed to not have hijab, then I had to change to their religion [Christianity]. It was very difficult to accept myself. Trust me, some nights I would cry. I would ask God to help me. I was depressed and I didn't know what is right and what is wrong. I would appeal to God to help me and I think God showed the right way to me … So I changed my religion and selected Christianity, then I took off my scarf. I am relaxed now. But before that I was so distressed. (Mahsa, 31)*

Growing up in a conservative family with strong religious beliefs prevented her from having a close relationship with Australians because of their different religion and beliefs.

In addition, her different appearance indicating her as a Muslim caused her stress when involved in social activities in the church. To reduce the feeling of isolation and fear of rejection, she decided to adapt to the new society by converting to Christianity. This problem-focused strategy was not easy and inflicted a great deal of stress on the participant for a long period of time, although, after a while she adjusted to the substantial change.

7.3.2 Adjusting life plans

Analysis of the narratives in this study revealed that limitations sometimes produced opportunities for individuals to explore other options in their lives. To enhance their quality of life, the women had to adapt to new circumstances and sometimes change their life aspirations in accordance with their new conditions and resources. For example, prior to migration some women had wished to study in Australia; however, due to their insecure residency status they were unable to. Failure to reach their life goals disappointed some participants inasmuch as they thought about returning to Iran. One participant tried to keep her hope alive through reprioritising and adjusting her life plans. While the initial plan of this participant was to study, find a job and then have a child, she reprioritised her life plan when she was informed about her visa condition, which deprived her from study.

> *I realised that I was not allowed to study and work. So, the best thing was to have a baby, because I should have done something. I should have something to be busy with. So, I became pregnant. If I could study and work here, I would choose to study first, then work, then have a baby … Now I am busy [with my baby]. I am waiting for my daughter to grow up. Then I can study and have a better life situation. (Nazi, 34)*

This highly educated participant felt useless in her new environment, so she chose to enact the part of her life plan that she could control in her current circumstances. She perceived

this decision as helping to prevent feelings of idleness and mental deterioration. She was the only woman in this study who did not report seeking help from mental health counsellors and psychologists. While it can be argued that having strong mental stamina helped this participant effectively navigate her life, being able to develop an adaptive coping strategy to readjust to new conditions prevented psychological harm.

7.3.3 Seeking support from formal and informal resources

Most participants strived to regain their lost resources, such as socio-economic status, social networks, and employment, or attempted to gain new resources, such as language skills, cultural information, and necessary qualifications to facilitate their resettlement in the new society. Participants sought support from informal and formal resources. Informal resources included friends and family members, and formal resources included religious communities and government-funded services and caseworkers. Majority of participants (n=12) pointed to their extended social network and friends as informal resources, who offered both emotional and instrumental support, helping them to survive in the new environment. Family members emerged as a great informal source of support. One participant, who had her first pregnancy and delivery in Australia, needed the support of her parents to look after herself and the newborn child; however, the current legislation on asylum seekers deprived her from inviting her parents to Australia. The resulting distress of being left unsupported could expose this participant to risk of post-partum depression; however, having a reliable and available source of emotional support, her husband, assisted her to overcome her feelings of loneliness and being unsupported.

> *I had a childbirth here and my mum was not allowed to come [to look after me]. It was difficult for me and still is difficult … [However] I have a very good husband. He is very kind and helps me …. He baths the baby … He helps*

> *me not to lose my spirit, not to get post-partum depression. [When I have a problem] I talk to my husband and he really helps me and talks to me … I haven't gone to a psychologist so far. (Nazi, 34)*

Contrary to all the other participants, who needed counselling services to deal with the adverse impacts of migration, this participant had no experience of using the services, despite clear risk. This reflects the significant role of family, friends and other informal resources in protecting these women against psychological harm.

Building and expanding social links was reported as another strategy contributing to a better mental health outcome for participants. Building social networks not only included having gatherings with Iranian friends, but also expanding relationships with the wider Australian community. One participant, who was at risk of serious mental health issues due to the return of her husband and children to Iran following her divorce, explained how forming friendships with others could save her from further emotional damage.

> *I already have some Australian and Iranian friends. They helped me to find a job. I could save money by working at a restaurant. My friends have helped me very much. They cried with me [when I was crying] … I got crazy the night that my children went back [to Iran]. My friend stayed in my home and told me 'don't be alone, you will get crazy'. She asked me to work in her hair salon. She invited me for dinner to her home … Now I work with her and I feel calmness. (Sima, 39)*

Although she still needed psychological support to deal with the distress of divorce and losing her children, the sympathy and emotional support from her friends was important in protecting her from serious psychological harm. Similarly, another participant whose partner returned to Iran benefitted from her social relationships. The support she received from friends also empowered her to achieve her aspiration and find a job.

> *I saw many angels here. When my boyfriend left, my friend introduced me to a lady who was another angel for me. She helped me in writing my CV and we sought a job together … Another angel is my landlady. She cooks for me. She supports me psychologically. (Nasrin, 35)*

Referring to supportive people as 'angels' reflects the significance of these people in this participant's life. She perceived her losses and difficulties as being so massive that only an extraordinary power or a miracle could help her. Having supportive people around her assisted her to live a relatively normal life.

Sharing stories and experiences with others was another strategy that some participants used to receive support and reduce the burden of stress. Speaking out about negative experiences and feelings assisted some participants to mitigate the adverse mental effects of stressful circumstances. The excerpt below indicates that talking about negative experiences with other people, while not changing her situation, temporarily decreased her stress.

> *I am homesick but I feel calm when I talk to my sister. She listens to me, my close friend too. When I talk to her [close friend] I feel happy. (Elena, 28)*

Talking about her concerns with a close friend with whom she shared memories from childhood helped the participant to alleviate the pain of negative experiences. While other participants tried to build new relationships and social connections, this participant found it more helpful to share her experiences with people she already knew.

In contrast, those who had no family members or close friends in Australia, talked about their adverse experiences and worries with psychologists and counsellors as formal resources. One participant expressed how talking to a psychologist made her feel better and ameliorated the adverse effects of ongoing problems. Counselling sessions facilitated

the participant to speak out about her life-threatening experiences without fear of being misjudged.

> *Being visited by a psychologist was good for me … There were many things that I couldn't talk about them to anyone. I would tell them to the psychologist. After each visit I would get a severe headache, but after a while I would feel well … The doctor would tell me 'you should remember what has happened to you. They [negative experiences] will become indelible if you forget them. If you bury them inside yourself, they will turn into [physical] sickness' … You [the researcher] are like a psychologist. It is a long time [that] I haven't met my psychologist. This interview allowed me to talk and now I feel happy. (Nasrin, 35)*

Apart from the informal resources that provided the women with emotional and instrumental support, many participants attempted to gain further support, particularly financial support, from formal resources. The lack of secure residency followed by the lack of a reliable source of income inflicted financial restrictions on most participants. However, identifying and using formal resources of financial support enabled them to afford their daily basic needs. The formal resources included government-funded organisations, such as Settlement Services International and religious communities, such as churches.

> *There were some centres that would help asylum seekers who held bridging visas. My caseworker in SSI [Settlement Services International] really helped me. Since I was single, she did not give me financial assistance, but she helped my home mate because she had a kid. She [caseworker] gave us new stuff …Then, our life started to become normal. We could rent a home. Then we went into the city. I saw the Opera House, I was excited … We started our normal life. (Fariba, 35)*

The supportive role of caseworkers was highlighted in most interviews as easing the participants' resettlement through providing them with financial support to rebuild a relatively comfortable life in Australia. The financial support helped the participants meet their basic daily needs, and provided a sense of settlement and belonging in the new environment.

The youngest participant in this study, who gave birth to a child in Australia, described her caseworker as a supportive resource. This participant received assistance from her caseworker in completing the official paperwork related to her childbirth. Since the participant was not proficient in speaking English, her caseworker's support was critical in processing the necessary paperwork.

> *I don't have financial issues because my caseworker assists us … My caseworker gave me voucher twice. She is very nice. When [my baby] was born, she offered me to choose some stuff for the baby and she bought them for me … She is an Australian lady. I haven't done anything for my child [paperwork]. I [only] completed the forms at home. Then she processed all the paperwork. She supported me. Her support is excellent. She is very kind and tries to understand me although my English is not good at all. (Hale, 25)*

Interestingly, the participant's language deficiency did not affect the support she received from her caseworker, who was a native English speaker. She believed that the empathy from her caseworker helped surmount their verbal communication barriers.

In addition to support with financial and administrative matters, another participant emphasised the role of her caseworker in assisting with her child's health issue. Faced with long waiting lists for care, the caseworker arranged an emergency visit. Without the support from her caseworker, she might not have been able to access timely treatment for her child.

> *To be visited by a doctor, I had to wait on long waiting lists same as others. But I had a good caseworker; she helped me to [make appointments] quickly [out of the queue]. (Neda, 32)*

In general, caseworkers were recognised as formal resources who substantially supported some participants solve problems they encountered during resettlement in the community. Having a formal and lawful supportive individual as a caseworker strengthened the participants to overcome their ongoing settlement constraints. In addition to caseworkers, some non-government organisations and charities such as the Salvation Army and The House of Welcome also provided financial support to some participants. Most participants were satisfied with the support they received from these organisations and recalled them as the very first formal resources that helped them to survive in their new environments. The excerpt below depicts a participant's gratitude for the financial support she received from these organisations.

> *Red Cross supports me for everything. It introduces me to other organisations such as the Salvation Army for financial assistance, for example, food voucher or second hand furniture. We would not have these supports in Iran. The House of Welcome loaned me in a very difficult situation to pay for the property bond, then I paid it off little by little. (Zahra, 27)*

As a sole parent with no special qualification and English language proficiency to secure a job, the financial support assisted the above participant to survive and settle in the new society. Comparing her situation in Iran where there were no such supportive resources for divorced women and single mothers, she appreciated the formal assistance in Australia that assisted her to live a normal life.

In addition, the role of charities in dealing with financial restrictions was evident. Through attending charity programs and church events, many participants, even non-Christians, received assistance.

> *There is a church that gives me formula, nappies, milk bottle, juice, milk and so on for my child … I know couple of Australian people who I met at the church. I moved to a new home and they lend me their van. They brought me a bed. One of them is an old man but he brought me a bed at midnight and installed it and told me 'don't sleep on the floor, you will get sick'. (Hale, 25)*

Overall, seeking support from various available resources was a strategy that helped the participants to cope and, in some cases, solve ongoing problems during resettlement in the new society. Emotional, instrumental, and financial support from formal and informal resources created a sense of being accepted and settled within the Australian context and alleviated their distress.

7.3.4 Positive thinking and maintaining hope

Having a positive outlook on their current life situation despite ongoing difficult circumstances such as living with insecure residency status emerged as an effective strategy that helped some participants maintain their mental wellbeing. Focusing on positive aspects of living in the new environment, such as enjoying safety, freedom, and support for women and children, and comparing these gains with their situation in Iran assisted the participants to enhance their resilience in coping with losses.

> *We were shocked at [the] first days of living in the community … I am a bit better now because gradually I found out I am safe and they [the Australian Government] care about my child. They care about my health … What might happen if I was in Iran with this [sick] child? What might happen if I had the same condition in Iran? (Nazi, 34)*

Highlighting the positive aspects of living in the new society helped the participants boost their optimism and positivity towards their living conditions in Australia. This emotion-focused strategy, although it did not fix anything, helped reinforce the purpose of their migration. With renewed commitment to their migration, they viewed the negative outcomes as tolerable in this instance.

Moreover, positive thinking empowered the participants to maintain their hope for a better future. While insecure residency disappointed most participants with improving their life situation in Australia, some participants attempted to keep their hope alive for a better future, find a meaning to their lives, and cope with losses and difficult situations. Different participants presented different types of hope for the future, including hope of being reunited with their family and children, hope of studying and building a better life, or hope of a bright future for their children in Australia. One participant, who had left her child in Iran, was hoping to be reunited with her son in the future in Australia. Although this seemed like a distant goal, it empowered her to tolerate ongoing post-migration difficulties and restrictions, and to maintain her mental health.

> *I can think freely about future that maybe one day I can meet him [my child]. Maybe I can meet my child in a better situation [in Australia]. He will come with me [to Australia] if he likes … Living here gives me hope and patience. Hope to find a way to see my child [in the future]. (Shiva, 30)*

Due to insecure residency, the participants were not allowed to reunite with family members who were still in Iran. The above participant was aware of the limitations; however, she remained positive by thinking that her refugee application would ultimately be processed and her child would be able to visit her in Australia. This hope helped the participants to proceed with a normal life in their new society.

7.3.5 Avoidance

While majority of the participants were positively trying to build a peaceful and productive life through defying existing problems, three chose to ignore their difficulties. These participants believed that ignoring problems they felt disempowered to solve, such as insecure residency, could reduce their stress so they could continue with their normal life. One participant stated that living with insecure residency and its consequences resulted in her relationship breakdown, and placed her at risk of serious mental health problems. Due to her inability to change the condition, she decided to avoid thinking about the loss. The strategy could not solve her problem practically, but emotionally it reduced her suffering.

> *I like to escape from the problem and don't think about that. I try to make myself busy with working. I have learnt how to escape from problems. I watch movies, work, and try not to be [alone] at home. I try to make myself tired [outside] then just watch movie and sleep at home. (Nasrin, 35)*

This participant, furthermore, explained her concern about her family left behind in Iran. She emphasised her concern about her parents' health. Because she was not able to return to Iran to support them physically, she decided to reduce her contact with them to keep herself uninformed of their condition. She believed that this strategy reduced her stress.

> *I am worried for my family … Sometimes I have nightmares about my dad, I see him in trouble … I try to lessen my contacts with my family because I fear [hearing] bad news … If something happens for my mum, dad, sisters and brother, what can I do here … I try to contact them fewer [times] to maintain my calmness. (Nasrin, 35)*

Avoidance was used to reduce the burden of stress; however, it could not protect the participant from mental health problems and the need for regular psychological counselling sessions, as noted in the above participant's experience of nightmares.

7.3.6 Spirituality

Similar to the transit period, participants applied spirituality and religiosity to reduce their stress of confronting difficulties of resettlement in the new society. As a result of finding themselves unsupported and disempowered to change their circumstances, six participants engaged in religious practices, such as belief in faith and praying. They believed that relying on a higher power could protect them against vulnerabilities. Spiritualty, although emotion-focused, was believed to reduce their stress so they were able to focus on their abilities and possessions to speed their settlement process. One participant elaborated how she kept her faith and prayed to cope with the stress of separation from her child. Praying and following Christian faith kept her hopeful that all sufferings could be over through intervention of a higher power.

> *I have religious beliefs and pray. I pray every night in bed. This helps me … I believe that God knows something that I don't. Maybe I get to know them one year later. I keep talking to God and I am sure he will help me … I haven't forgotten God. (Sima, 39)*

Similar to hope for the future, spirituality was used mostly by the more optimistic participants in this study.

Overall, the participants developed various emotion-focused and problem-focused strategies to facilitate their settlement and integration into the host society, and to protect themselves from developing mental health issues. The following chapter discusses the

study finding in relation to the wider literature and using the lens of the Resourced Based Model.

Chapter 8: Discussion

8.1 Introduction

This chapter discusses the findings about the experiences of Iranian asylum seeker women during migration and resettlement in Australia, and the impact these experiences had on their health and wellbeing. The RBM, introduced in Chapter 3, as well as the incorporated conceptual framework from the literature review, guides the discussion. According to the RBM, resource losses or gains in different phases of migration are interrelated and jointly influence forced migrants' perception of self and life, mental health, and adaptation to the host society.[289] Drawing on the model, this chapter discusses the participants' losses or gains during different phases of migration, which help determine their needs, goals, and demands during resettlement in Australia. It also discusses how access to key resources to meet their needs, attain goals, and manage demands was facilitated or constrained by personal and environmental factors, and the coping strategies developed or employed by the participants to overcome constraints and navigate their way to services and resources. Finally, the strengths and limitations of the study are discussed.

8.2 Summary of the key findings

This study explored the experiences of migration and resettlement of asylum seeker women from Iran who came to Australia by boats run by smugglers. The participants narrated their experiences through three phases of migration – pre-migration, transit, and post-migration. Analysis of the findings provided a rich understanding of the participants' experiences of migration and their resettlement challenges in Australia.

In general, migration inflicted various financial, social, political, and health vulnerabilities on the participants and their families. Analysis of the participants' stories revealed the factors that pushed or motivated them to leave their country and immigrate to Australia. Regardless of the different push/pull factors, the participants shared negative experiences and losses during transit and after arrival to Australia. However, their previous expectation of migration and living in Australia affected their tolerance and reactions to the encounters, such as travelling on the rickety and crowded boats, being detained in the prison-like immigration detentions, and lack of a secure residency in Australia. The participants shared their various experiences of using healthcare services in Australia. While some women appreciated the healthcare services, some others critiqued the discriminatory attitudes of healthcare providers and lack of culturally competent counsellors. The participants also shared the strategies they developed and used to help them adjust to their new conditions, gain new resources, regain their lost resources, meet their needs, , and maintain their mental health.

8.3 Theoretical application of the resource-based model

Understanding forced migrants' needs, goals, and demands over the three phases of migration, and the role of resource availability and constraints in their successful resettlement and health outcomes was the main reason for basing this study on the RBM.[289] Using this model to analyse the participants' losses, gains, and goals enabled the researcher to develop a thorough understanding of their needs and demands. This level of analysis goes beyond the existing overview about forced migrants' experiences in the literature. The existing literature often portrays refugees and asylum seekers as victims of traumatic events and psychological harm, while overlooking their resource gains and goal achievements. Further, in order to develop a deeper understanding of forced migrants'

needs and demands during resettlement, a thorough consideration of the host countries' attitudes and policies on immigrants is needed.[289]

The RBM also considers that the impact of lost resources on the coping abilities and mental health of forced migrants and their access and use of available resources are influenced by individual migrant's needs and goals. However, the model fails to discuss the significance of the coping strategies that immigrants develop and use to recompense their losses and strengthen their capacity to regain the lost resources.

8.4 Pre-migration experiences

Analysis of the pre-migration experiences provided a platform to understand the asylum seeker women's needs, goals, expectations, reactions to confronting difficulties during transit, their needs and demands post-migration, resource loss/gain, and their capacity to cope and build resilience in the new environment. Drawing upon the RBM, this study found that gender-related issues, such as living in a patriarchal culture and society, deprived the women from accessing empowering resources such as education, employment, and self-esteem to pursue their goals and meet their needs in their homeland. Throughout history, women have been subordinate to men in the conservative society of Iran in which the patriarchal belief affects women's lives.[161] Women in a patriarchal society are generally deprived of their legal rights, resources, freedom, and economic mobility.[386,387] Laws that encouraged gender inequalities had a negative effect on the women's social achievements, family relationships, and physical and mental health. In patriarchal societies, women are disempowered, devalued, and exploited.[388] Similarly, the women in this study stated that they had limited control over their circumstances before migration.

A study on Druze women, a traditional minority group in Israel, found that women had lower self-esteem than men. The authors argue that women's lower self-esteem is rooted in the patriarchal culture where women are subordinate to men, and are not allowed to express their feelings and values, while men have authority to make decisions about women's daily activities at home and in public.[389] Similar to this study's findings, Shirpak et al. (2011) blamed the patriarchal power structure in Iran that is generated from beliefs about inherent differences between men and women. The Iranian immigrant women in Canada believed that the patriarchal power rooted in differences in muscle strength between the genders and further enforced by religious laws.[390] In line with the current study findings, Shirpak et al. (2011) state that these patriarchal beliefs have resulted in social and legal restrictions for women that hinder them from standing up for their basic rights, such as limited conditions in which women could obtain divorce.[390] In contrast to the study by Shirpak et al. (2011), which did not reveal gender inequality as a pushing factor for Iranian women's immigration to Canada, this current study's participants clearly expressed their frustration with the gender inequalities in Iran. Their negative feelings and experiences were reasons for leaving their home country and seeking a place to fulfil their basic human rights where they could access and gain resources to enable them to rebuild a new life, and feel empowered and authorised to navigate their lives. The differences in the reasons for immigration between these two studies can be related to sample variation. Role of informational resources, including social media, in increasing awareness of women's rights and the ways of seeking justice in recent years should not be overlooked.[391] This raised awareness on one hand and powerlessness to effect change in their own country on the other, seems to encourage more women to seek their rights in countries where there is gender equality. However, adjustment to the new society was hampered in both studies by some women carrying their traditional culture, accompanied

by long-term disempowerment of women. Therefore, asylum seeker women's background and pre-migration experiences should be taken into account when designing resources and support services for this population.

Jamarani (2012) depicted Iran as a patriarchal society, in which women have to follow their husband's decisions, even about where to reside.[392] All of the women in Jamarani's study who immigrated to Australia obeyed their husband's decision to leave Iran. This reflects the widespread patriarchal attitudes affecting many aspects of Iranian women's lives. Despite this, some women went beyond their culturally described roles of only taking care of the family and raising children after immigration. The new society in Australia made them aware of their rights and helped them step out of their cultural restrictions to redefine their roles within their families and society.[392] The existence of legal and financial support, for example support for victims of domestic violence, can empower women from traditional societies to redefine their role within their families and society.

On the other hand, as found in this current study and Jamarani's (2012) study, this transition is often not welcomed by the women's husbands, resulting in relationship breakdown and divorce. While divorce was seen as an 'opportunity' in Jamarani's and the current study, it inflicted psychological concerns in the women. Disruption of the unity of the family and separation from children were the main concerns of the women after divorce in both studies.

While in Jamarani's (2012) study, all the women said they had to follow their husband's decision to immigrate, none of the women in the current study mentioned having to follow their husband's decision for immigration. Instead, they cited reaching a place with human rights and gender equality, and self-sacrifice for the family as their reasons for

immigration. Again, this may reflect sample variation or increased awareness of Iranian women of their rights over the last few years.

Referring to the RBM, immigration to Australia empowered the women, in the Jamarani's and the current study, to obtain supportive resources and determine new goals and meanings for their lives. Therefore, the influence of a patriarchal culture should not be underestimated when providing supportive programs for women from the similar cultural background.

Self-sacrifice for the family in order to keep them safe and secure was a factor that pushed some participants to leave their country. Many studies introduce sacrifice as a gender-related issue, where women are more willing to disregard their interests to protect their family members and maintain the unity and wellbeing of the family.[388,392-394] Some feminist theories, however, argue that sacrifice does not always contribute to positive outcomes.[395] For example, women who obligate themselves to make sacrifice for their intimate partner or family may suffer from higher levels of depression and relationship dissatisfaction.[395] In line with the RBM, in cases of excessive sacrifices, women may feel a sense of great loss but no achievement, which increases their risk of depression. For example, in the current study, some participants' partners started a new relationship outside of their marital relationship after leaving Iran. Loosening of family bonds was perceived as an additional loss by the women; in particular, for those who had made sacrifices to protect their husbands by giving up a settled life, leaving behind their families and established social networks, and accompanying their husbands through a life-threatening journey. Most participants, however, perceived sacrifice as a positive contribution to their family and something they were proud of.

In general, Australia is known as a high-income country where residents enjoy a high standard of living and many opportunities.[396] After European countries and Canada, Australia has been a chosen destination for Iranian immigrants over recent years.[244,397-399] International economic sanctions resulting in tangible economic restrictions for families in Iran[398,399] on one hand, and higher living standards in developed countries, such as Australia,[396,400] on the other, have motivated many Iranians to immigrate to these Western countries. Lack of financial resources and limited work opportunities have frequently been reported as factors pushing Iranians to seek resources and build a comfortable life in developed countries.[21,401] Apart from these factors, reaching safety, stability, gender equality, and freedom were frequently cited by the participants in the current study as reasons for immigration.

According to the RBM, there is a relationship between the nature and level of resources lost and the needs, goals, and demands the participants encounter during transit and resettlement in the host country.[289] In other words, if immigrants are able to meet their needs and reach their goals in the host country, they may feel compensated for their losses, while an inability to meet their needs or goals can increase their sense of loss. For participants in the current study, reaching freedom, stability, safety, and gender equality in Australia seemed to mitigate some of the resources the women had lost over the process of immigration; however, an inability to control and manage their life circumstances due to the lack of secure residency status and its consequences hindered their feeling of fulfilment and empowerment.

8.5 The transit experiences

For many immigrants, the transit phase itself is a period of experiencing hardships and losses.[289] As explained in Section 8.4, participants left their resources in Iran to reach

safety, stability, freedom, and gender equality, and to gain a sense of power and control over their lives. However, they found their situation in transit very different to their expectations. Loss of resources, on one hand, and being kept in an insecure condition in Indonesia where they had no control over their circumstances on the other, made some participants distressed about their decision to migrate.

Transit and its related costs and losses are viewed as an investment for a better life and future in a host country.[289] However, the extended and undetermined transit period the women in this study experienced resulted in significant loss of resources such as money, health, legal residency, and control over their circumstances. These losses, along with the fear of being deported to their country of origin, led to psychological loss in the participants during transit. Briskman et al. (2016) report similar findings when they interviewed asylum seekers from Iran, Sri Lanka, Afghanistan, and Pakistan in Indonesia awaiting their settlement in Australia. The asylum seekers reported that they had to rely on their savings for basic necessities as most did not receive financial support from humanitarian organisations in Indonesia. Lack of financial resources resulted in an inability to protect their privacy and afford basic needs such as food, transport, clothing, and healthcare. These experiences were recalled as traumatic by the asylum seekers.[402] The longer the stay in transit, the greater the vulnerability of asylum seekers to losses and their consequences. Challenged with difficulties in transit for many years, such as financial issues, safety, boredom, and lack of legal rights, inflicted mental health issues on the participants in Briskman et al.'s study (2016). However, given the short period of stay in Indonesia, the associated mental health issues seemed to be less for the participants in the current study.

Despite short period of stay in Indonesia, the participants reported a number of adverse experiences during transit. Loss of privacy was perceived as a stressful condition, experienced as an obligation to share their belongings or personal territory with strangers. They had to live in crowded and poor quality accommodation that lacked sanitation; conditions that jeopardised their health and safety. The RBM and its theory of a 'resource loss spiral' considers that those with greater material and social resources experience less stress.[289] Accordingly, forced migrants who travel with their family members and enough money to afford private accommodation in transit countries are expected to experience a smoother transit and less disruption to their personal space. However, unexpected delays in departure reduced the resources of many participants in the current study.

Looking through a wider lens, the pre-migration experiences of participants in this study seemed to influence forced migrants' tolerance towards transit difficulties. While some participants found it traumatic to see their privacy invaded, others found the situation tolerable. The latter group seemed to be from lower socio-economic backgrounds. Moghissi (1999) relates Iranian women's coping ability to their cultural-historical background, in which women, in particular those from lower socio-economic status, had to live within extended families.[282] These women had learnt to constantly cope with new situations through their past experience of living with new people who sometimes had different values, attitudes, and lifestyles.[282] This cultural background seemed to help the women to be content and resilient towards their difficult migration. In addition, those who had experienced hardship or trauma before migration seemed to be more tolerant and resilient towards the hardships of the journey. For example, those who fled persecution did not complain of their poor living conditions during transit. For these women, losing resources such as privacy and living in poor conditions were tolerable when they

considered the safety they achieved by leaving Iran. This finding lends support to the RBM, which posits that the needs and goals of individuals determine the impact of resource loss or gain during the transit.[289]

Loss of control over their life and resources was another negative experience that distressed participants during their stay in Indonesia. A sense of powerlessness to make decisions about their migration process added to the asylum seekers' stress. They had to obtain their smuggler's permission for even small decisions. Being left in an uncertain condition and relying on smugglers to make a decision about their journey was perceived as devastating and stressful. A feeling of powerlessness and loss of control may have contributed to a sense of hopelessness, worry, and lack of self-control in these women. These findings are in line with research carried out on asylum seekers from Iraq, Iran, Syria, and Afghanistan while awaiting their refugee application results in refugee camps in Greece.[403] Bjertrup et al. (2018) report uncertainty and lack of control over life circumstances as the common concern of this population. The inability to make decisions for the future, and a sense of powerlessness to control their life events created significant emotional and mental distress.[403] Moreover, the historical background of being under control in Iran in a male-dominant society made the women in this study more conscious of their status of powerlessness in transit. Sedghi (2007) depicts a picture of Iranian women's transition during the last century. She describes how women in Iran had to adjust to the rules that were mainly determined by a male member of the family or legislated by male politicians. In such a society, women are seen as dependent, emotional, vulnerable, and under the control of male-dominated rules and traditions. They merge their identity into their husband's after marriage and become virtual properties of their husbands, mostly due to financial dependency. Being dominated by men for many years devalues

women's identity and lowers their self-esteem and locus of control over their lives.[404] Finding themselves powerless in Indonesia resembled the participants' status in Iran; an experience that generated the sense that their investment in reaching independence and freedom was destined to fail.

Participants in this study also conveyed their stressful experience of loss or disconnection from their family members during transit. In previous studies, losing family members was experienced by asylum seekers in the form of witnessing the death of family members during the journey or leaving them behind in countries of origin with little hope of visiting them in the near future.[202,405,406] In the current study, some participants experienced a temporary loss in the form of disconnection from their children and husband, mainly at departure time in Indonesia, or a permanent loss related to the death of a family member during the journey. In line with the concept of resource loss in the RBM, temporary loss of family members, even for a short period, distressed the participants. Witnessing the death of a family member inflicted severe mental health problems, necessitating ongoing psychological treatment. The need for special mental healthcare and regular counselling services after more than two years from the event affirms the significant impact of permanent loss of family members on the participant's mental health and quality of life in both the short and long term. Miller et al. (2018) conducted a mixed-method study on refugees from Iraq, Afghanistan, and Great Lakes of Africa who settled in the USA. The study explored mental health consequences of separation from family members. The results of the study demonstrated that leaving behind family members with little hope of reuniting with them in the future, created a great deal of distress and negative mental outcomes. Leaving the family members behind in the unsafe situations contributed to their ongoing anxiety and affected their ability to maintain their positivity.[407]

In addition, women who travelled alone reported fear of sexual violence and exploitation by smugglers and male counterparts during transit, although none experienced actual sexual violence. A recent study reported Syrian refugee women's experiences of sexual violation confronted over their journey.[207] In the refugee crisis, the women lost their financial resources. Inability to pay the smugglers for their journey obliged them to engage in sex to pay smugglers to avoid delays in their onward journey. The Syrian women described the sexual assault as the 'price' of their passage.[207] This is in line with the concept of resource loss in the RBM that posits that loss of financial resources on one hand and the need to protect their lives on the other forced some women to engage in sex, which resulted in lasting psychological trauma.[207] In contrast, the participants in this study carried financial resources to pay smugglers. Despite their ability to pay for their journey, the participants were still conscious of, and stressed about, being sexually abused during the transit based on stories of previous asylum seekers. The perception of such fear seemed to also be related to the participants' pre-migration experiences of being abused as a woman in a patriarchal culture, where men had the utmost control and authority over women, an experience that produced a sense of vulnerability and subordination of women to men.[161]

Prior to migration, most participants expected the journey to be a trip during which they would spend some time in a transit country as a tourist, and then travel safely to Australia. However, they found it an arduous journey in which they endured significant losses and scarcities, and confronted dangers. The magnitude of the losses was beyond the tolerance of some participants inasmuch as they produced a sense of regret about their decision to immigrate. Although most asylum seekers went through similar experiences, those with traumatic experiences pre-migration seemed to have more capacity to cope with the

challenges of transit and were less likely to feel regret about their decision to migrate. Lending support to this finding, Hoffman (2012) found that leaving a condition of war or political conflict with little chance of returning to their home country strengthened Iraqi asylum seekers to make the best of their situation in transit instead of expressing regret.[406]

Hope of reaching safety and freedom in the near future enabled the participants in this study to cope with their transit hardships. While they were distressed about losing resources and feared being deported to Iran, they endeavoured to control their stress by applying emotion-focused coping strategies, such as maintaining their hope for a better future in Australia and engaging in spiritual practices. Hoffman's (2012) study on Iraqi refugees, who had spent several years in Indonesia before settlement in Australia, revealed that at the beginning of their journey in Indonesia, the asylum seekers coped with the difficulties of transit by maintaining their hope for a better life in Australia; however, after years of living in Indonesia their hope faded.[406] Eventually, their coping strategies were shifted towards problem-focused strategies, such as getting involved in voluntary work by teaching skills to other Iraqi asylum seekers. This helped them to ruminate less on their condition in Indonesia, such as insecure residency, uncertain future, and risk of being deported to Iraq. However, the long-term stay with limited resources discouraged them and increased the risk of mental health issues.[406] In contrast, the participants in this study did not report any problem-focused strategy to cope with difficulties in transit. Their short duration of stay in Indonesia may have rendered engaging in more active coping strategies unnecessary.

Overall, the findings of this study suggest that asylum seekers endure significant losses and psychological distress during transit to host countries. Further studies need to investigate the impact of the length of transit on asylum seekers' psychological wellbeing

and their coping abilities during resettlement in a host country. The following section discusses the participants' post-migration experiences in light of the host country's policies, environment, and attitudes towards asylum seekers; factors that affect immigrants' settlement, integration, and psychological wellbeing.

8.6 Post-migration experiences

Analysis of the data revealed that migration affected participants' metal health. As mentioned in Sections 8.4 and 8.5, traumatic pre-migration and transit episodes can leave prolonged mental health problems; however, post-migration stressors can be more influential in hampering forced migrants' resettlement in a host country and their psychological wellbeing.[408] Confronting mandatory detention, lacking secure residency and subsequent social outcomes, living in a diverse linguistic and cultural society, and difficulties in accessing and using healthcare services were key difficulties that affected participants' health status, in particular their mental health. Building resilience through using coping strategies and adjusting to the new environment was another key finding.

Hynie (2018) conducted a critical review of the primary research and systematic reviews on the relationship between post-migration trauma and psychological disorders in refugees and asylum seekers. It explored the impact of post-migration traumatic experiences and the availability of supportive resources on this population's mental wellbeing. Those living in immigration detentions in low-income countries demonstarted a higher rate of mental health issues. But the prevalence also vary amongst high-income countries, and these differences were related to exposure to difficult situations,[408] such as insecure residency and lack of work or study permission.

According to the RBM, forced migrants' post-migration experiences and psychological wellbeing is likely to be affected by the resources they carry, gain or regain in the host country.[289] Consistent with Ryan et al. (2008), this study found that successful resettlement, integration, and wellbeing of the participants was influenced by their resource pool, which was affected by immigration policies that could strengthen or devalue skills and resources.[289] Immigration policies in Australia have undergone major changes over the last few years. The recent changes in immigration policies and regulations aim to reduce illegal entry to the country, making the conditions harder for those who have entered the country illegally.[409] The findings of this study shed light on the impact of these recent immigration policies on boat arrival asylum seekers' lives and health over their first years of settlement in Australia. In general, Australia's current policies against asylum seekers who arrived by boat have contributed to their resource losses, unmet needs, and goals in the host country. The findings related to the participants' experiences after arriving in Australia are discussed in two main parts; experience of mandatory detention and living in the community.

8.6.1 Experience of mandatory detention

Australia has been at the forefront of implementing immigration policies that aim to limit the flow of asylum seekers to this country over recent decades.[263] Mandatory detention of asylum seekers who enter Australia by boat and without a valid visa is a stringent immigration policy that has provoked many concerns for new arrivals.[263] Participants in the current study experienced varying periods of detainment in different detention centres in Australia before being released into the community. Experience of detention varied according to the centres. While most participants expressed their satisfaction with the living conditions and resource availability, such as food, hygienic facilities, and

healthcare services, at the Darwin detention centre and the ITA in Adelaide, those in the Christmas Island detention facility perceived it as difficult to meet their basic daily needs. This finding provides a platform for further studies to investigate asylum seekers' perceptions and experiences of living in different detention centres in Australia, and the impact of these differences on health and the future wellbeing of asylum seekers. An examination of policies and regulations in different detention centres is also warranted.

The inclusion of mandatory detention experiences under post-migration experiences in this study is consistent with the RBM. The model considers the duration of detention in host countries as part of the post-migration phase.[289] In the current study, all the participants assumed themselves in Australia when referring to their feelings and experiences in detention centres, perceiving their life in detention as a part of their post-migration life. This is contrary to previous studies conducted in European countries and the USA, which have discussed experiences of asylum seekers during detention as a part of transit.[410,411] This inconsistency may be related to the geographical space in detention and individuals' expectations of the destination. In Kimball's (2007) study, for example, asylum seekers from South and Central America intended to cross the Mexican/USA border and settle in the USA, but were arrested and detained in immigration camps in Mexico operated by Mexican police and immigration staff.[411] In contrast, participants in the current study were detained in detention centres situated within Australia's states and territories[412] and operated by Australian border force and immigration staff.

According to the RBM, the psychological impact of mandatory detention and associated negative experiences are related to pre-migration and transit experiences.[289] Reviewing the participants' pre-migration experiences and their reasons for migration produced a more complete view of their overall experience of detention. In other words, pre-

migration experiences, reasons for migration, and transit experiences affected the participants' perception of their living conditions in detention. Ryan et al. (2008) describe detention as a prison-like environment where individuals are treated like criminals, are under extreme control, and have little opportunity to gain resources. In this situation, individuals are not able to maintain their dignity, self-esteem, and hope for the future.[289] In this study, women with a background of being under the control of men in a patriarchal society may have perceived mandatory detention as a barrier to their freedom and self-esteem, and a sense of being criminal, with the tension created making them regret their decision to migrate. Consistent with this finding, previous studies have criticised the designated spaces as resembling a prison and threatening asylum seekers' psychological wellbeing, in particular those with a background of torture, oppression, or confinement.[263,413,414] Re-experience of being under control in a prison-like environment makes it difficult for asylum seekers to heal from past psychological injuries.[289,413,415]

Although the enclosed environments of the detention facilities hindered the participants from accessing new resources or limited their attempts to compensate for lost resources, some women acknowledged a sense of relief and safety that the secured environment of the detention centres produced. Mirza's (2014) study lends support to this finding, suggesting that the circumscribed spaces of detention facilities offer asylum seekers, in particular those who fled prosecution, the basic care and protection of the international humanitarian community.[416]

Despite the prison-like infrastructure of detention centres, the way the participants were treated by staff in these centres influenced their perception of their confinement as a prison or a secure place. While some participants were stunned by the welcoming behaviours of immigration detention officers, others were shocked when they found

themselves being treated like criminals. Some participants related the attitudes and behaviours of the staff in detention centres to the current immigration policies against boat arrivals. However, Coffey et al. (2010), who conducted their study before the implementation of the new immigration policies, consider the varying behaviours of immigration detention officers as arbitrary and personal.[417] They suggest that protracted detention resulted in a boring life contributing to engagement of asylum seekers in maladaptive behaviours, such as self-harm or protest, and in response to these behaviours, detention officers are likely to react in unjust and inhumane ways.[417] Although the participants in this study spent a relatively short period in detention centres, and did not report breaking rules, some participants still perceived the behaviours of some detention officers as unjust and inhumane, such as separating them from family members or limiting their access to healthcare services. Although expressed by only a few participants, these behaviours are concerning and have been found to result in a sense of worthlessness and a feeling of discrimination and mistreatment.

While living in a prison-like environment and perceiving mistreatment and discriminatory behaviours could result in long-term psychological and mental problems, the participants did not report serious concerns, possibly because the short-term detention protected them from lasting adverse psychological outcomes. In 2013, detention centres became overloaded due to global turmoil and the influx of asylum seekers in Australia. In response to this problem, immigration policies were reviewed by the Department of Home Affairs with the aim of reducing the overall number of detainees in immigration detention. As a result, detainees who had entered Australia by boat in 2012-2013 were released into the community after an average of 90 days in detention while their refugee applications were still being processed.[418,419] Since the current study participants' arrivals

in Australia coincided with the immigration overflow and the policy renewal, they experienced a relatively short period of detainment, ranging from four weeks to about four months. In previous studies, prolonged detention was found to create long-term psychological consequences.[263,417] Coffey et al. (2010) interviewed refugees from Middle-Eastern countries including, Iran, Iraq, and Afghanistan in Australia, who had been granted permanent residency at the time of study. They had spent an average length of three years in immigration detention, and were released into the community, on average, 44 months prior to participation in the study. The study revealed that the participants were still suffering from an ongoing sense of injustice, insecurity, difficulties with concentration and memory, persistent anxiety, and depression.[417] Although Coffey et al. (2010) claim that long-term detention contributed to prolonged psychological problems in asylum seekers,[417] the relationship between duration of detention and short and long-term psychological harm needs to be studied using appropriately designed quantitative studies.

Overall, the policy of mandatory detention has been frequently criticised by human rights activists and health researchers.[218,263,413,414,420] The findings of this study confirmed some adverse effects related to detention experiences, such as a sense of powerlessness and feeling humiliated and treated like a criminal in a prison-like environment. Nonetheless, this study revealed some benefits in short-term detention for new arrivals, including creating a sense of safety and security, and providing an opportunity for asylum seekers to recover from previous physical and psychological traumas before facing the challenges of living in a new socio-cultural environment. Most participants migrated with minimal personal, social, and material resources, such as financial resources, family, and skills. These participants found detention was an opportunity to recover from their pre-migration

trauma and gain some resources before being released into the new society. Building social networks in detention, for example, helped the women to partially compensate for the loss of friends and family ties, and increased their self-confidence. In addition, the detention centres offered English classes and skills training, which, although very basic, empowered the newcomers to face challenges of resettlement in a new society. Offering training and resources to asylum seekers during their detention period had the advantage of accessibility, as the asylum seekers had more free time and inspiration to learn necessary skills, and they did not have to pay for transport to attend the classes. Although these classes were found useful, cultural orientation classes, or information on the healthcare system of Australia, housing, transport, and services for their children, such as childcare facilities, could have eased the transition of the asylum seekers to living in the community.

Detention also provided the opportunity for health screening to detect and treat injuries and transmittable diseases, which in some cases, helped improve the asylum seekers' health. Chaves et al. (2017), on behalf of the Australasian Society for Infectious Diseases and Refugee Health Network of Australia, recommend a comprehensive health assessment for asylum seekers and refugees within one month of their arrival to allow for early detection and prevention of transmissible diseases. In addition to physical health screening, the immigration policy offers asylum seekers a screen for mental health issues as part of the initial onshore health assessment and counselling services for survivors of torture and trauma.[421,422]

8.6.2 Experiences of living in the community

This study recruited Iranian asylum seeker women who had lived two to three years in the community in Sydney awaiting a decision on their refugee application. The

participants shared their ongoing challenges of resettlement in a new socio-cultural environment, which was aggravated by current immigration policies. The lack of secure residency status and the resultant consequences emerged as a strong theme from the participants' experiences of living in the community. While the women were free to live in the community, travel around Australia, and receive social services, such as access to government-subsidised education for their children and free access to primary healthcare services, they lacked security in terms of their residency status in Australia. Insecure residency status not only affected their socio-economic status, but also inflicted severe psychological harm, social exclusion, and family relationship breakdown. In some cases, the participants' residency status also affected their access and use of healthcare services. For example, lack of employment and a secure income, which were mostly linked to the asylum seekers' insecure residency, lessened affordability of specialist services and dental care.

8.6.2.1 Living with insecure residency

Living with insecure residency created living in 'in-between' and a limbo condition for the participants. In limbo, there is no certainty, rules can be changed at any moment, and people must be ready for unforeseen events at all times. It is confusing and frightening to live in this situation for an indeterminate time.[423] In previous studies, asylum seekers experienced a limbo condition while they were living in transit countries or in detention awaiting a decision on their refugee applications.[233,406,424-428] In these studies, asylum seekers were trapped in a condition whereby they could not return to their origin countries or relocate in a destination country. This condition was described as "neither here nor there".[233] However, participants in the current study explored a different experience of living in limbo. They lived in a limbo condition in the community where they were not certain about their current and future life. Compared to previous studies, the current study

participants mostly experienced a short-term stay in transit and detention. As a result, they were able to maintain their hope for a better life in Australia while in transit and detention. These differences should be taken into consideration when comparing the experiences of asylum seekers in different immigration phases across studies.

Recently, researchers in the field of humanitarian studies have expressed concern about holding asylum seekers in a 'standstill' residency status within destination countries and have referred to their condition as limbo.[76,423,429,430] Over the last decade, Australia's policies against asylum seekers have resulted in many asylum seekers living in an uncertain residency condition for an undetermined period. As a result, concerns have arisen about asylum seekers' ability to settle in the host society and the impact this may have on their health and wellbeing.[233] Hightower (2013) found that a sense of being in limbo, resulting from indefinite detention, inflicted a great burden of mental distress on asylum seekers. Moreover, those who had been released into the community with a TPV, perceived their living condition as insecure and still in limbo. These conditions caused psychological fragility and the need to take a mix of anti-depressant and sleeping medications.[233]

In general, living in limbo, either in detention, a transit country, or in the destination country, is perceived by asylum seekers as years wasted.[431] The participants in the Olliff's study (2014) revealed their sense of helplessness and nervousness of their lives wasted while living in Australia awaiting a decision upon their refugee application.[431] Likewise, participants in the current study described their experiences of living on a bridging visa in the community as living in limbo. This condition generated uncertainty about residency status and limited their ability to study or work, and diminished their motivation and efforts to adjust to the new society. The socio-economic ramifications of insecure

residency include unemployment, no permission to study, difficulties in obtaining housing, exclusion from the host society, and negative impacts on family relationships. These social disadvantages in addition to the fear of being deported to Iran, confusion, and feeling hopeless, increased the women's psychological problems and their need for prolonged mental health counselling and treatment. These findings lend support to the Hightower's study (2013) which states that living with insecure residency has been found to contribute to anxiety and social isolation, hampering asylum seekers' integration and increasing their risk of mental health problems.[233]

The RBM hypothesises that gaining resources or replacing lost resources can compensate for migration-related losses and positively impact on forced migrants' psychological wellbeing, adaptation, and integration into the host society.[289] The model adds that having greater resources contributes to better opportunities and facilitates achievement of further key resources, integration, and eventually better mental health.[289] Consistent with the RBM, participants in this study who had greater resources, such as English language proficiency and social networks, had more job opportunities due to their ability to locate, apply, enter, and secure a job successfully. However, having greater resources did not necessarily guarantee better mental health. All women in this study described various constraints they confronted during settlement in the host society as a result of insecure residency. Although having the key resources, such as English language proficiency and social networks, protected them from feeling isolated and excluded from the host society, it did not compensate for their greater loss; secure residency status. These findings indicate that insecure residency is an important factor that leads to further losses in asylum seekers and impedes the gain of key resources. It is critical to note that when discussing adjustment and integration issues post-migration, the RBM focuses on experiences of

refugees in the host country. As discussed in the introduction to Chapter 1, refugees have a big advantage over asylum seekers, as they have secure residency and PPV, while asylum seekers live in a limbo condition for an indeterminate period,[432] either in a transit country or in the destination country. While refugees and asylum seekers may be similar in terms of enduring adverse pre-migration and transit experiences that influence their resettlement demands, needs, and goals, immigration policies against asylum seekers hinder asylum seekers' access to appropriate resources to meet their needs and goals. Consequently, asylum seekers generally show poorer integration and mental health.[345,432]

Regardless of the socio-economic status of participants during pre-migration or post-migration, and the key resources they carried to Australia, participants in this study linked their ongoing need for mental health support to their insecure residency status. Although the role of other factors, such as pre-migration experiences, cannot be ruled out in the women's current mental health status, living in uncertain conditions for a long period can have damaging effects on mental health.[433] Guajardo et al. (2016) compared the mental health of Iraqi asylum seekers who lived in Australia for more than four years with those seeking asylum for less than six months. The researchers found a positive relationship between prolonged asylum procedures and depression, anxiety, and other mental health disorders.[26] However, a more recent Mixed-method study comparing Iraqi and Afghan asylum seekers living in Netherlands for varying lengths of stay, found a more direct relationship between dissatisfaction of people with their socio-economic status and their psychological issues.[434]

Despite regular use of mental health services over two to three years of living in the community, the participants in the current study were still in need of continuing mental healthcare. While the ongoing settlement challenges no doubt contributed to the poor

mental health of the Iranian asylum seeker women, as the RBM suggests the role of pre-migration experiences in defining the needs and demands of forced migrants should not be overlooked. Iranians have passed through several major events over the last four decades that began with the 1979 Islamic revolution, followed by the eight-year war of Iran-Iraq. Further, international sanctions against Iran and ongoing political and economic unrest have inflicted significant adverse effects on Iranians' wellbeing, in particular mental health.[244] Although statistics demonstrate improvements in the quality of the healthcare system and health outcomes in Iran after the 1979 revolution,[435] comparing the results of mental health surveys in 1971, 1998, and 2011 raises concerns about the increasing prevalence of mental health disorders in this country. The 1971 mental health survey reported the prevalence of mental health disorders at about 12%.[436] This rate increased to 21% in 1998[436] and 23% in 2011,[131] near to the time when this study's participants left Iran in 2012-2013. In all these surveys, women from lower socio-economic status showed higher rates of mental health disorders.[131] Although women are often at greater risk of mental health problems than men globally ,[437] Grochin et al. (2014) argue that the dominant patriarchal culture that violates women's rights, such as making decisions for their marital relationships, incurs more mental health issues in Iranian women.[438] The impact of adverse events over the last four decades may also be greater on Iranian women than men. Therefore, the adverse pre-migration experiences indicate that Iranian asylum seekers, in particular women, enter the host country with poor psychological resources, a factor that increases their vulnerability post-migration. Health providers in host countries, therefore, should be aware of this background when providing care to Iranian immigrants.

8.6.2.2 Housing and employment

Apart from insecure residency status, difficulties related to housing and employment were commonly experienced by the asylum seekers in this study. While having resources such as English language skills and extended social networks helped some participants find a job, their visa condition and insecure residency was still an important obstacle to finding a fairly paid job, a job that matched their qualifications, or to secure a job and income. Their failure in employment contributed to housing difficulties and resultant mental distress. A qualitative study by Ziersch et al. (2017) introduced housing and employment as key social determinants of asylum seekers' mental wellbeing. They interviewed 22 asylum seekers from African, South-East Asian, and Middle-Eastern countries living in South Australia to explore the impact of their visa status on their experience of housing and employment.[439] The study participants recounted their inability to afford an appropriate home, where they could feel safety and comfort, affected their mental and physical health. Affordability of suitable accommodation was directly related to their residency status and visa conditions. Those who could afford a convenient property expressed their happiness and mental wellbeing, whereas others suffered from a sense of disintegration and mental health disorders, including depression and anxiety.[439]

In addition to insecure residency status, lack of rental history in Australia and inadequate knowledge about the Australian housing market hindered the asylum seekers' ability to rent property. This finding supports the Refugee Council of Australia's report on the difficulties of asylum seekers in entering longer term leases.[439] The Refugee Council of Australia (2014) submitted recommendations to the Australian Government to be considered in planning the forthcoming year's program for housing of humanitarian entrants. Provision of adequately resourced caseworkers, full and equitable access to social services, funding for interpreters and other multicultural services, and affordable

housing were identified as strategies that could support asylum seekers in finding sustainable housing.[440]

Moreover, the women in this study recounted stigma and the negative attitude of the host society against asylum seekers as aggravating their circumstances. Consistent with this finding, previous research reports that a negative portrayal of asylum seekers by the media and immigration policies created a negative attitude amongst the public that boat arrivals were illegal immigrants and a threat to Australia's security.[441,442]

Overall, the lack of secure residency, and being labelled as illegal immigrants in the media and in political language hindered the participants' access to employment and appropriate housing, which hampered their resettlement and elevated their mental distress. While the nature of relocation in a new environment makes housing and employment challenging for all immigrants,[112] lack of secure residency and social stigma makes it particularly challenging for asylum seekers.[345] The RBM lends support to this finding and suggests that changes to immigration policies are needed to modify the host society's public attitudes towards forced immigrants to facilitate their settlement and adaptation into the host society, and maintain their psychological wellbeing.[289]

8.6.2.3 Perception of discrimination and social exclusion

Exclusion from the host society was another mental health-threatening experience that participants confronted post-migration. This happened due to lack of resources, including English language skills, self-confidence, familiarity with the socio-cultural norms of the host society, and social stigma towards asylum seekers and their appearance that introduced them as people from a Middle-Eastern country. The women recalled experiences of racist behaviours, either verbal or non-verbal, which created a sense of not being accepted by the host society. Yet, they were likely to miss some cases of racist

behaviours due to cultural and language barriers. Perception of racial and discriminatory behaviours excluded some participants from social activities and decreased their confidence in communicating with the host community. Consistent with these findings, previous studies in Australia found that negative attitudes of Australian people towards forced immigrants increases the risk of social exclusion for refugees.[443-445] Stereotyping attitude was more obvious when refugees were identifiable with different appearances, names, accents, lower language ability, and religious customs. Refugees from ex-Yugoslavia, the Middle East, and Africa with visibly different appearances were particularly at higher risk of being stigmatised and discriminated in public and in workplaces in Western Australia. For example, to receive a positive response from employers, they had to change their Islamic names in their resume. Moreover, after success in securing a job they usually faced difficulties in gaining promotion.[446]

Self-stigma was also noted in some of participants in this study. Being labelled as 'boat people' and illegal immigrants by the media and the public[442] discouraged some participants from socialising for fear of being misjudged and stigmatised. While some had resources, such as English skills to facilitate socialisation and inclusion in the host society, shame of being stigmatised as illegal immigrants forced them to cut connections with Australian people. The participants also chose not to socialise with people from their fellow country, for similar reasons. These experiences corroded the potential advantages of existing resources and hindered access to further resources, such as developed social networks to gain more support. Exclusion from the society and resultant increased difficulties of settling in the new country inflicted ongoing psychological harm.[447] The RBM lends support to this finding by arguing that host countries' policies and attitudes

against forced immigrants can devalue their resources, hamper integration, and endanger their psychological wellbeing.[289]

8.6.2.4 Experience of cultural incongruity

Changes in family roles and expectations of family members, and concerns about children's adoption of Australian culture emerged as a significant challenge that the participants confronted during resettlement in Australia. Changes in expectations were perceived as a dual experience. On one hand, as the participants became aware of their rights and gender equality in Australia, they started to appreciate the advantages that immigration brought, and were satisfied with their decision to immigrate to Australia, despite insecure residency and ongoing migration-related difficulties. On the other hand, conflicts arose from changes in the traditional roles of couples, resulting in frequent family conflict, relationship breakdown, and ongoing mental health disorders in some participants. Hatoss and Huijser (2010), in their qualitative study on Sudanese refugees in Australia, explored a salient change in the cultural roles of women within their families. In traditional Sudanese culture, women are expected to stay at home and look after their family's needs, while men are supposed to work out of home and be the breadwinner for their family.[448] However, access to educational opportunities in Australia improved Sudanese women's employment chances. In the new situation, their husbands had to take on some women's chores to support their wives to study or work. While this role shifting was welcomed by the women, it was taken as disrespecting or disobeying their husbands in their traditional culture.[448] Contrary to the Hatoss and Huijser (2010) study, the majority of participants in the current study had tertiary education and were employed in Iran. Iran has been recognised as a country in the phase of modernism through which women are increasingly taking on men's roles and responsibilities within their families and the wider society, but regulations are still generally in favour of men, and men are

still seen as breadwinners for their families.[133] Similar to the Sudanese men, the participants' husbands in this study had to take on some home chores in order to provide support for their wives to work in Australia. This role shifting was accepted and supported by the new society and the women. However, in some cases it was not accepted by the men, and consequently family conflicts arose resulting in relationship breakdown and even divorce. Despite the adverse outcomes and psychological issues, the women perceived themselves as empowered to control their lives.

Equality in job and social opportunities for both genders in Australia could empower forced immigrants to regain the cultural, material, and social resources they lost during migration.[289] Becoming involved in working helped the participants in this study increase their knowledge about cultural aspects of living in a new society. They also became more confident in communication with English-speaking people. Moreover, the women were able to achieve dignity and freedom by living in a society that offers support for women; however, this achievement, at times, conflicted with traditional values the women carried, resulting in marital relationship breakdowns and subsequent psychological harm. To reduce culture shock and resultant family conflicts and psychological ramifications, the current study suggests cultural orientation programs be considered upon arrival for both men and women to help with successful resettlement and maintaining the mental wellbeing of forced immigrants from traditional societies.

Although some participants fled Iran due to the hindrance of living in the patriarchal society, they still expected their daughters to maintain some aspects of their traditional culture. They were particularly sensitive to the behaviour of their daughters, and not so much of their sons. This sensitivity towards daughters arises from Middle-Eastern culture, where girls are seen as vulnerable and there is an emphasis on the modesty of girls, while

it is more acceptable for boys to follow their own way of living.[162,449] Similarly, in a study by McBrien (2011), Iranian refugee women in the USA revealed concerns about their children's assimilation to the dominant culture, in particular their daughters. They were distressed about their daughters' disrespectful behaviours towards seniors, such as school staff. The women were distressed about their daughters' relationships with boys at school or inviting them home. However, their daughters seemed to be well adapted to the new environment and culture.[77] McBrien suggests cultural awareness training for refugee parents in the USA,[77] which could also be applicable in Australia. Cultural awareness can increase parental understanding of the mainstream cultural features that are unknown in their own culture.

8.6.2.5 Utilising healthcare services and meeting healthcare needs

Participants shared their experiences of accessing and utilising healthcare services during their settlement in the community in Australia. Apart from insecure residency that reduced the affordability of specialist care, participants shared both negative and positive experiences of using available healthcare services. Previous research suggests that existing health issues are likely to be exacerbated by post-migration difficulties, including insecure residency, financial restrictions, poor access to healthcare services, social isolation, family role changes and the associated conflicts, and language barriers.[450] To develop appropriate services for this population, a clear understanding of their healthcare needs is imperative. This study examined participants' health needs and experiences of utilising healthcare services to provide both the healthcare system and policymakers with rich knowledge about the needs of this culturally and linguistically diverse minority.

Access to healthcare services was a controversial experience in this study. In Australia, asylum seekers who live in the community have variable access to Medicare or

International Health and Medical Services depending on the type of visas they hold.[451,452] Medicare is a nationally funded health insurance scheme that provides access to free or subsidised healthcare services to Australian residents who meet eligibility criteria. It provides free hospital services for patients in public hospitals and free medical services, such as consultations with general practitioners. It also partially subsidises privately insured patients and consultations with specialists.[453] All participants in this study were eligible for Medicare services or International Health and Medical Services and, therefore, had free access to primary healthcare services.[43] The participants with no major health issues were generally satisfied with their access to healthcare services. In contrast, those in need of special healthcare services, such as dental or speciality care found their access restricted due to the lack of adequate financial resources. Previous studies outline other barriers, such as long waiting times, difficulty in making a medical appointment, and discriminatory behaviours from healthcare providers, as disturbing asylum seekers' access and utilisation of healthcare services.[28,454] This study's participants recounted similar issues. Some participants who were not satisfied with the healthcare services in Australia, related long waiting times and low-quality care in emergency departments, other medical departments, and counselling services to ignorance and discrimination of asylum seekers by healthcare providers. However, overcrowded public health sector and emergency departments and delays in provision of care is a concern for many Australian residents, regardless of their residency status and ethnicity.[455] Long waiting times in emergency departments causes frustration and anxiety in patients and their families. While the participants in this current study tend to put the blame on doctors and nurses, participants in the study by Ward et al. (2017) blamed the under-resourced healthcare system, in which staff are over-worked and the health needs of patients remain unmet.[455] This inconsistency in attitudes towards healthcare providers can be related to the lack of

knowledge of current study participants about the healthcare system in Australia and its shortages and challenges. Johnson et al. (2008) explored healthcare providers' experience of working with asylum seekers and refugees who settled in South Australia. The providers attributed low-quality care to high patient volume and shortage of practitioners in socio-economically disadvantaged areas where refugees and asylum seekers often lived rather than to discriminatory attitudes of healthcare providers.[456]

The participants were also dissatisfied with the level of communication and interaction they had with healthcare providers. This barrier resulted in some patients refusing their prescribed treatment, which aggravated their physical and mental health. In this regard, a report by Milosevic et al. (2012) on the NSW Refugee Health Service with the aim of improving refugees' and asylum seekers' access to services, presented concerns about the negative impact of the lack of effective patient-provider interaction on patient satisfaction with services and their health outcomes.[451] In a qualitative study undertaken on immigrants' experiences of interaction with physicians in Australia, lack of adequate patient-provider interaction resulted in feelings of isolation and being provided with poor healthcare.[457] Poor patient-provider interaction has been mainly attributed to language barriers. Inability to communicate with healthcare providers prevented immigrants from requesting clarification about their health issues or expressing their concerns and needs, resulting in an inability to gain information about their health and medications, as well as the emotional support they needed. As a result, their health needs were left unmet.[457]

In addition to language barriers, cultural incompetency of healthcare providers was perceived as a barrier leading to poor interaction. The participants believed that doctors should be familiar with cultural aspects affecting their health. For example, they expected practitioners to pay attention to their lifestyle, diet, physical activity, and ongoing

difficulties when making a diagnosis, and not only focus on physical symptoms. They did not perceive this as a lack of medical competency, rather unfamiliarity of health providers with their culture, which led to their distrust of the diagnosis and prescribed treatment plan. Truong et al. (2014) undertook a systematic review to explore the impact of the cultural competency of healthcare providers on patient-provider interaction and care plan outcomes. They conclude that culturally competent healthcare providers may be more skilful in obtaining medical histories, which helps them reach a rigorous diagnosis. In line with the current study, some included reviews found a relationship between cultural competency of healthcare providers and patient adherence to treatment. However, some other reviews did not find the relationship. The systematic review recommended a variety of interventions to improve healthcare providers' cultural competency. The majority of reviews found several positive outcomes, such as an improvement in access and utilisation of healthcare services, and cost effectiveness.[458] A more recent study on Somali women in Finland by Dengi et al. (2012) demonstrated a positive relationship between cultural competency of healthcare providers, patient-provider interaction, and health outcomes.[459] Similarly, another study was undertaken on immigrants from China, Sudan, Vietnam, and those from Arabic-speaking background living in Australia. The authors, Komaric et al. (2012), found that cultural incompetency of healthcare providers contributed to their poor understanding of patients' health issues and poor treatment outcomes.[460] Komaric et al. (2012) recommend developing culturally tailored programs to prevent and manage chronic disease in immigrants from diverse cultures. They believe that high-quality healthcare for culturally diverse minorities can be achieved by investing in culturally competent programs.[460]

In addition to poor physical health outcomes, the mental wellbeing of the participants was also affected by poor patient-provider interaction. The participants narrated their poor interaction with counsellors, which negatively affected their health-seeking behaviours, satisfaction with counselling sessions, and treatment outcomes. In line with this finding, evidence from other research suggests that patients who have good interactions with their mental health providers exhibit favourable treatment adherence.[461] Interactions that could promote empathy, information sharing, and reassurance and support for patients were missing in the experiences of mental health services by the current study participants. Counsellors from a culturally and linguistically diverse background were found ineffective and unhelpful in improving mental health outcomes[15] for the women. While cultural competency of mental healthcare providers is important in achieving optimal patient outcomes, the dissatisfaction of study participants of provided mental healthcare could be related to their lack of knowledge about different styles of counselling. Listening is core to different counselling modalities. Counselling requires the counsellor to 'be there' and 'listen to' the client.[462] The participants, however, seemed to perceive this technique as 'too passive' even if the counsellors paid full attention to clients.

Dissatisfaction of the participants with healthcare services may be due to their low health literacy and lack of knowledge of different treatment techniques. Health literacy refers to the capacity of individuals to seek, obtain, and understand basic health information and healthcare services in order to make appropriate health decisions. A large body of research on the health literacy of immigrants draws a relationship between migration as a social determinant of health and lower health literacy of immigrants. These studies demonstrate a link between immigrants' language skills, residency status, cultural beliefs, and availability of informational resources about healthcare services of host countries and

health status of immigrants.[463-465] While lack of health literacy may impact all immigrants' health status, asylum seekers are considered more vulnerable due to their previous experience of trauma and their post-migration difficult circumstances as described in Section 8.6.

Drawing upon the key components of the RBM, immigration policies of the host country can impose restrictions and delays in accessing resources by forced migrants, such as accessing and utilising healthcare services.[289] Some participants in the current study believed that the politically driven healthcare system in Australia hindered access to appropraite health information, which resulted in lasting physical and mental health issues. This finding is consistnet with the results of a systematic review conducted by Hadgkiss and Renzaho (2014), which examined environmental and social factors that hamper asylum seekers' utilisation of healthcare services in an international context.[28] In the case of Australia, they reveal that the political environment of the healthcare system, influenced by current immigration policies, not only impacted on quality of care and health information refugees and asylum seekers received, but also hindered conducting research to explore the barriers of care for this population.[28]

In general, migration of any type has been viewed as a social determinant of health. While immigrants tend to be healthier than native populations upon arrival, their health status tends to deteriorate over time due to factors, such as systematic marginalisation and discrimination.[466] The complex interactions between immigration and health yet to be explored; however, they are a significant determinant of disparities in health and wellbeing between immigrants and native populations. Immigration is also a consequence of the social determinants of health. The social determinants of health include "the conditions in which people are born, grow, live, work, and age. These circumstances are

shaped by the distribution of money, power, and resources at global, national, and local levels".[467] Social determinants include access to quality schools, reliable transportation, high quality housing, employment, and so on.[466]

Without doubt, adverse life experiences place asylum seekers at greater need of supportive health resources, such as Medicare, Pharmaceutical Benefits Scheme (PBS), and access to a wide range of health and welfare services, including healthcare cards if eligibility criteria are met. However, asylum seekers who arrived by boat generally lack access to PBS and are entitled to temporary Medicare, which is conditional on having a valid bridging visa.[468] Lack of opportunities to secure a well-paid job coupled with lack of access to PBS may hinder asylum seekers from affording required medication, thereby delaying or impeding their treatment.

8.6.3 Adjusting to the new environment and building resilience

This study explored migration-related experiences, including the gains and losses that affected the participants' health and wellbeing and sense of integration into the host society. Despite communal traumatic experiences, the participants demonstrated different levels of integration, resilience, and mental wellbeing. Resilience refers to a person's ability to channel inner strength, optimism, competence, flexibility, and an ability to cope effectively with adversities.[469] Ryan et al. (2008) critique the transactional model of stress and coping[470] for over-emphasising individuals as responsible units in managing stressful conditions and enhancing their resilience by applying coping strategies,[289] and consider the important role of access to key resources in facilitating forced immigrants' ability to regain resources to meet their needs, goals, and demands to feel integrated and psychologically healthy. The RBM suggests that the host country's immigration policies

may restrict access to resources, hampering resource gain and adaptation of forced immigrants.[289]

Drawing upon both the Lazarus and Folkman (1984) model and the RBM, this study explored the strategies the participants individually developed and used to access limited available resources in the presence of restrictive policies and constraints to help them adjust to their new living conditions. They applied both problem-focused and emotion-focused coping strategies to navigate daily life situations. These coping strategies were thoroughly presented in Chapter 7 and the findings are analysed and discussed in the following section.

8.6.3.1 Problem-focused coping strategies

All participants acknowledged that in order to overcome migration-related difficulties and adjust to Australia's way of living, culture, and rules, they needed to reinforce their social and cultural capacities. Engaging with the host society, adjusting life plans, and seeking support from formal and informal resources are strategies that individuals adopted to enhance resilience, develop skills, and facilitate their access to resources through meaningful actions to meet resettlement demands.

Through application of problem-focused coping strategies, the women were able to participate in social activities, build networks and find jobs, although mainly volunteer or low paid. These activities created a sense of usefulness, and being engaged in, and identifying with, the new society. These achievements were particularly important for women who had an active and productive life before migration. Meaningful engagement in social activities through volunteer work and attending social events emerged as a strategy that assisted the women improve their English language skills and cultural awareness. Through these opportunities, they developed interpersonal skills and felt

settled and accepted in the new country. The beneficiary effects of engagement in social activities and volunteer participation on maintaining psychological wellbeing have been well documented in the literature.[471,472] Nevertheless, access to these opportunities seemed a challenge for some participants, in particular, for those with caring responsibility for their children. These women often felt themselves isolated and a burden to the host society. Provision of childcare supports may facilitate isolated women's participation in social activities and voluntary jobs.

Building social networks was likewise perceived as an effective strategy to enhance the women's resilience and maintain their psychological wellbeing, particularly in those who had lost their social connections through migration. Through social activities and interactions with others, the women were able to engage with others, gain emotional support, and divert focus from their ongoing difficulties. The expanded social networks further helped some participants find a paid job, which improved their capacity to build a more settled life and gave them hope for a better future in Australia. Consistent with the experiences of participants in this study, Syrian refugees in Canada narrated how building or developing social networks facilitated their access to resources through provision of emotional and material support.[473] In line with the RBM, better access to employment opportunities and housing increased their optimism for the future and resilience towards settlement in a culturally diverse community.[289] Moreover, a sense of being in the community and supported by people from the same background led to improved mental health.[473]

Adopting some aspects of the new society and culture emerged as another problem-focused coping strategy in this study. While immigrants may leave their own beliefs and values in the process of assimilation,[3] some participants in this study adopted those parts

of the new culture that helped them feel accepted and settled in the new society while maintaining a large part of their own culture. This partial assimilation facilitated their resettlement, while protecting them from being isolated by the Iranian community. Berry (1997), who introduced assimilation as a strategy that eases the adaptation of immigrants in new societies, believes that assimilation can be successful if both the original and host country have a positive attitude towards accepting new cultural aspects; otherwise, assimilation may lead to exclusion of the individual.[3]

Adjusting life plans was another strategy that increased some participants' resilience towards the restrictive immigration policies for asylum seekers who arrived by boat. A study on Syrian refugees, who had experienced living in Jordan before settling in European countries, identified readjusting their life plan as an active strategy through which individuals constantly develop their plans to achieve the goals they set.[474] When their life plans were unachievable in Jordan, they changed their plan of living in Jordan and moved to European countries. The ability to readjust life plans helps individuals use their available resources efficiently, maintain their hope, and enhance quality of their life. In the current study, the participants actively restructured their responses to stressful situations to control their stress. While the recent immigration policies hindered the asylum seekers from pursuing their goals, such as study and work, they enhanced their resilience and control over their lives, and maintained their hope for the future via introducing new goals.

In addition to the aforementioned strategies, seeking support from formal and informal resources emerged as the women strived to increase their access to key resources to be able to meet their needs, goals, and demands post-migration. Seeking support from informal resources, such as friends, family members, and community, is a common

practice amongst immigrants to ease their settlement in a new environment.[475,476] Women in this study sought information about the social and cultural norms and values of the new society from their ethnic community, and learnt about available resources to facilitate their resettlement. They also tightened their relationships with friends and family members (if available), as sources of support. In general, informational and emotional support were the most common forms of support provided to the participants by informal resources. Folkman (2010) views seeking emotional support as an emotion-focused coping strategy through which individuals regulate their negative emotions;[477] however, the participations in this study actively sought emotional support to help them "manage and alter their problem causing distress".[478]

In addition to seeking informal support, the women sought support from formal resources, in particular caseworkers, who helped them through the provision of material resources, such as a life allowance or renting a home. These supports were perceived as crucial in helping the participants find their feet in the new environment and alleviating their stress in the early days of living in the community. However, in another qualitative study conducted in Western Australia, asylum seekers from Afghanistan were not satisfied with the material support they received from their caseworkers. Although they had been granted permission to work and expressed great motivation to work, the practical support of caseworkers in helping Afghani refugees find a secure employment was limited.[479] It was more important for these people to be supported to find a job and work than being entitled to receiving financial support from the government. The current study participants were, however, satisfied with financial, and in some cases emotional, support they were receiving from their caseworkers. The inconsistency might be related to the fact that current study recruited only female participants, while Fleay et al. (2016)

included both genders. The cultural attitude that women are not responsible for breadwinning in traditional societies[480] may have caused the women to be satisfied with receiving financial support.

8.6.3.2 Emotion-focused coping strategies

Emotion-focused coping strategies have been defined as strategies that regulate emotional responses to a problem.[470] Two patterns have been recognised for emotion-focused coping strategies; disengagement and effort to explore one's emotions. While disengagement is viewed as maladaptive and relates negatively to psychological wellbeing, the latter is adaptive and leads to improved psychological wellbeing.[481,482] In the current study, the analysis of narratives revealed the variety of adaptive and maladaptive emotion-focused coping strategies participants applied to manage their migration-related stresses.

The participants mostly narrated their efforts to locate formal and informal resources, such as counsellors and close friends, to share their stories and express their emotions. For those with limited informal resources, visiting a counsellor on a regular basis to express their emotions seemed to be useful. Sharing stories and experiences has been presented as a commonly used emotion-focused coping strategy by forced immigrants.[190,483] For example, displaced Sri Lankan people who survived the tsunami in 2004, shared their stories with those who had similar experiences in order to express their painful emotions.[483] Talking about their feelings helped them to "get pain out of their chest".[484] Moreover, through story sharing, they learnt about different others' coping strategies, which also helped them adapt to their new situation and increased their resilience after the disaster and during displacement.[483] However, similar to the current study, the displaced Sri Lankan people found limited formal trustworthy resources for

sharing their experiences and emotions. These resources included religious leaders, village Buddhist monks, priests of the churches, or leaders of mosques.[483] Women in the current study stated that access to formal support, such as psychological counsellors, was helpful and created a sense of relief.

In addition, some participants used avoidance techniques to avoid overthinking their problems and to alleviate the associated distress. For example, some avoided following up news from Iran and stayed disconnected from people or conditions that would add to their distress. Consistent with Lazarus (1993), the study found avoidance as an emotion-focused coping strategy through which individuals ignored or avoided stressors to manage and alter their emotions.[485] Similarly, Sulaiman-Hill and Thompson (2012) state that "thinking too much" about current affairs in the host country and following news from the country of origin could re-traumatise forced immigrants even after years of settlement in destination,[219] whereas being positive about their current life situation and remaining hopeful about the future predicted positive psychological outcomes and higher resilience.[486,487] Some participants in the current study tried to highlight their achievements in Australia, such as freedom, gender equality, and safety. Recalling their positive achievements and comparing them with their situation in Iran elevated their optimism and enhanced their resilience towards migration-related stressors. Consistent with this finding, Jewish refugees, who lost their all resources during migration to France and the USA, applied positive thinking and reinforced their hope for the future and optimism towards their current life condition. This helped them rebuild a new life in their new country. They preferred to be referred to as 'immigrants' or 'newcomers' rather 'refugees'. They believed that this empowered them emotionally and helped them to assume host countries as their own.[488] Due to the lack of secure residency, adverse

immigration policies, and portrayal of asylum seekers as illegal immigrants in the media, it was difficult for the participants in the current study to feel Australia as home, but they kept their hope alive for a bright future in this country, where they would enjoy equal human rights as legal immigrants.

Some participants fostered their hope and positive thinking through embracing spirituality. Similar to this study, spirituality, either in the form of belief in a higher power or religious practices, has been used by refugees in other research as a buffer against their stressful conditions.[486,489] In other words, in facing stressful circumstances, such as insecure residency, those participants who showed a more positive attitude towards their future and higher resilience towards ongoing resettlement difficulties tended to resign themselves to the situation and place their faith in the hands of a higher power.

In general, the women in this study applied both emotion-focused and problem-focused coping strategies. The emotion-focused strategies enabled them to manage their stresses and emotions temporarily, so they could employ problem-focused coping strategies to more effectively tackle their post-migration challenges and gains.[490] As outlined in the RBM, these strategies helped the women to gain resources, such as finding a job, solving their housing issues, gaining social support, and improving their English language skills. Gaining the key resources motivated the women to more actively engage in identifying and developing problem-solving coping strategies, which helped them maintain their mental wellbeing and integrate into the new society.

Overall, being an asylum seeker, a person in the condition of uncertainty, may discourage individuals from active engagement in developing problem-solving strategies to integrate into a new society. Moreover, the immigration policies against this population and limited formal support hinder their resettlement and integration to the new society. Living in this

adverse situation for a prolonged period can have destructive effects on the health and wellbeing of asylum seekers.

8.7 Limitations and strengths of the study

This study has some limitations that should be acknowledged. Its cross-sectional nature hampered a complete understanding of the experiences of resettlement and the health status of the studied population. The process of resettlement is a dynamic experience and changes across time. This study, therefore, was limited in exploring the mechanisms of integration and the impact of coping strategies on individual's resettlement and mental wellbeing in the long term. However, the findings of this study facilitate a platform for understanding Iranian asylum seeker women's past experiences, their ongoing post-migration challenges during the initial years of settlement, and how encounters in different phases of immigration are interrelated and determine asylum seekers' needs and demands in the new society.

This study yielded significant information regarding Iranian asylum seeker women's experiences of migration, resettlement, and the health impacts; yet, due to the nature of the study design, the findings cannot be generalised to the broader population group. Since recruitment was undertaken in Sydney, people living in other cities might share different experiences of resettlement in terms of housing, work opportunities, perception of stigma and discrimination, and use of healthcare services.

The recruitment of minorities in research is often challenging.[491] However, this study used effective strategies including location sampling and snowball sampling to overcome recruitment barriers. The recruited sample may not be representative of Iranian asylum seeker women in Sydney, as those with severely traumatic experiences and higher levels

of mental health issues are likely to avoid social interactions that reduce their chance of being recruited to research studies, or they may not be willing to go through their traumatic experiences in an interview. Additionally, some people may not fully understand the purpose of research, and be afraid of sharing their stories with researchers, particularly while they are awaiting a decision on their refugee application. Bearing in mind these barriers, the researcher approached participants through a trusted community leader. Further, the researcher spent considerable time establishing rapport and trusting relationships with the community that enabled obtaining deep, rich, and reliable data. The heterogeneity of the participants in terms of age, education, socio-economic background in the country of origin and in Australia ensured that a variety of experiences and narrations were captured in the interviews.

Language was another limitation that needs to be acknowledged. Interviews were undertaken and transcribed in Farsi/Persian, and translated to English in the next phase. Since meanings were sometimes lost in word-for-word translation, translations were made in such a way to convey the meaning of the original text. To ensure the accuracy of the translations, the principal supervisor, who is fluent in Farsi/Persian and English, and has vast experience in translating Farsi/Persian texts to English, closely reviewed the accuracy of the translations.

Similar to other qualitative studies, the researcher's prior knowledge about the study population may introduce bias to the interpretation of the participants' experiences. However, this can also be considered a strength of this study. Being a woman and mother coming from the same socio-cultural background, familiarity with current social, political, and economic issues in Iran, and having some common resettlement experiences in Australia contributed to the researcher's immersion into the topic and placed her in the

role of the ‘insider,’ to a degree. This offered the researcher easier access to the study participants, better understanding of their experiences within the social, cultural, and political contexts of Iran and Australia, and appropriate interpretation of the participants’ nuanced responses and reactions.

The following chapter provides the conclusions of the current study, and incudes recommendations for policy, practice, and future research.

Chapter 9: Conclusion and recommendations

9.1 Introduction

This qualitative study provided rich and comprehensive information about migration and resettlement experiences of Iranian asylum seeker women, who lived in Sydney, Australia for two to three years at the time of the interviews. Analysis of the participants' experiences during three key phases of immigration: pre-migration, transit, and post-migration enabled a thorough understanding of Iranian asylum seeker women's health and socio-cultural needs in Australia. Forced migration is a process of relocation through which individuals often endure traumatic experiences with the hope of reaching safety and securing a better life in a destination country,[289] which does not necessarily always happen. Based on analysis of the narratives in this study participants experienced adverse socio-cultural conditions before migration, including gender inequality, disempowerment, persecution, and economic and political unrest, which they were unable to change. These adverse living, social and cultural conditions seemed to disempower the women, reducing their self-esteem, sense of dignity, hope, and power to pursue their life plans and goals in their home country. They immigrated to Australia with the hope of reaching safety and freedom, and achieving equal gender rights, self-esteem, and a sense of dignity as women in this country.

Regardless of their reasons for migration, almost all participants found themselves disempowered to control their lives and circumstances during transit, both in Indonesia and on the boat. They perceived transit as a period of constant losses, which threatened their physical and mental health. However, considering transit as a temporary phase and

maintaining their positivity and hope for a brighter future in Australia helped the participants tolerate the difficulties.

Upon arrival in Australia, all participants faced compulsory detention. During the period of detention, most participants continued to feel disempowered and humiliated; feelings that had forced them to leave their homeland in the first place. In general, detention was perceived as disadvantageous; however, a few participants perceived it as helpful for recovery from their previous trauma before release into the new socio-cultural environment. These participants were grateful for the sense of safety and security that detention provided, for free access to healthcare services, and the opportunity to build social networks. Although limited, the participants were offered English lessons and skill training, which they hoped to use in the future.

The women's feeling of disempowerment and not belonging carried over to living in the community due to insecure residency. Insecure residency status caused further adverse resettlement experiences including unemployment, housing difficulties, lack of permission to study, financial problems, inability to reunite with their families who were left behind in Iran, and exclusion from the host society. Current immigration policies and political discourse against boat arrivals[441] hampered a sense of being accepted, protected, supported, and welcomed, and augmented social stigma and discrimination. Their portrayal as 'boat arrivals', 'illegal immigrants', and 'queue jumpers' in the media resulted in prejudicial attitudes within the Australian context towards asylum seekers,[492] adding to their settlement challenges and mental distress. The negative attitude created a gap between this population and the host society, increasing the risk of isolation and social exclusion. Stress relating to loss, insecure residency, the asylum process, immigration

policies, discrimination, social exclusion, and socio-economic difficulties in the host society affected the asylum seekers' health, in particular mental wellbeing.

In addition, the women experienced cultural incongruity, which led to confusion and conflicts between family members. Lack of orientation about the host society's norms, values, and culture and resulting family conflicts or even family breakdown added to the stress of resettlement.

Access to primary healthcare services was facilitated by being eligible for Medicare or International Health and Medical Services.[43] However, long waiting lists, language barriers, perception of discrimination from healthcare providers, and lack of effective interaction with health professionals were identified as health-related challenges. The perception of stigma and discrimination from healthcare providers is concerning[28] and the participants related this to the politically drawn healthcare system. These adverse experiences could affect health-seeking behaviours of asylum seekers and compliance with treatment regimens,[28] widening the gap in health outcomes across different social groups.

In general, traumatic experiences related to pre-migration, during transit, and compulsory detention followed by difficulties during resettlement in the host society negatively affected the participants' health and wellbeing inasmuch as at the time of interviews, all participants except for one were in need of psychological counselling services, and in some cases psychiatric treatment for lasting mental health issues. This signals an important area of focus and should compel action for both policymakers and the healthcare sector. The women strived to build resilience and gain the control of their lives through adoption of emotion-focused and problem-focused coping strategies.

This study enabled a thorough understanding of the socio-cultural and health needs of Iranian asylum seeker women who live in Sydney, Australia. Consistent with the RBM, it was found that the needs, goals, and demands of these women were influenced by experiences they had in different phases of migration and to the magnitude of their resource losses or gains. The understanding gained through this narrative enquiry enabled the researcher to understand the implications of the study, and possibilities for changing practices and policies to facilitate resettlement of asylum seekers in the community, build capacity, and enable these people to overcome their challenges and feel accepted within the new society.

9.2 Implications for policy

All participants in this study presented living with insecure residency for an undetermined period as the main reason for their significant adverse experiences and challenges post-migration, and the main contributor to their ongoing mental health problems. Despite regular use of psychological counselling services over two to three years of living in Australia, almost all the participants were struggling with mental health issues. To have an integrated and productive population, this study suggests some implications for immigration policies.

To prevent long-term psychological harm, detention should be re-introduced on a discretionary basis. The duration of detention should be minimised and limited for the purpose of security checks, identity and health examinations.

Since the protracted process of refugee applications may have negative effects on asylum seekers' health and lead to constant resource use with limited chances of gaining new resources,[17,493] policymakers should review the existing policies and remove restrictive

barriers that slow the process. Moreover, the re-introduction of PPV to asylum seekers who are recognised as genuine refugees is recommended. This gives them assurance about the future and allows them to plan their lives with some degree of certainty.

The socio-economic ramifications of immigration are substantial, hampering asylum seekers' successful resettlement and psychological wellbeing. Currently, there are services that offer asylum seekers a range of support, such as financial and material aid, health services, and personal support, including advice about employment and housing, and access to mainstream community networks. Despite the availability of these services, none of the participants in this study mentioned being aware of these services or utilising them. This may be due to the services being overwhelmed by the growing number of newcomers at the time of arrival of this study's participants. To increase the efficacy of the support services, this study suggests funding for ongoing programs such as 'orientation to Australia', 'integration', and 'developing communities' that should start from detention and continue over the early years of resettlement in the community to assist asylum seekers to access them. Informational sessions can be offered to increase awareness of asylum seekers about norms and cultural aspects of living in a culturally diverse society. These programs ensure awareness about the services available in the community, such as healthcare, housing, transport, and services for their children, such as childcare.

Communication barriers including English language deficiency, social isolation, and lack of confidence hindered the women' resettlement in the host society. The barriers conflicted with extending social networks, securing a job and income, and obtaining necessary information about the new socio-cultural environment. Language barriers were found to reduce the women's communication and interaction with healthcare providers,

which reduced their ability to discuss their health concerns and receive necessary heath information, contributing to poor health literacy and health outcomes for this population. While a number of humanitarian and volunteer organisations, such as the Asylum Seeker Resource Centre, Asylum Seekers Centre, and NSW STARTTS offer some English lessons and training for asylum seekers, awareness of these services was not evident. There is also no government-funded English training program available to this population. This study recommends that the Adult Migrant English Program or the Advanced English for Migrants Program that already offer 510 hours of English language training to immigrants including refugees, PPV holders, and some temporary visas, extend their services to include asylum seekers on bridging visas.[494]

Social stigma against asylum seekers was found to hamper their resettlement and sense of integration and belonging to the new society. Negative portrayal of asylum seekers as 'illegal immigrants' and 'queue jumpers' in the media and government documents has amplified stigma against this population.[492] This study recommends referring to asylum seekers as 'newcomers' or 'protection-seekers' in the media and government documents to avoid labelling them as illegal immigrants. This may help protect asylum seekers from discriminatory and bullying behaviours.

Moreover, housing difficulties are real and important constraints on the resettlement of asylum seekers. Being able to rent a property provided the women in this study with a sense of belonging and acceptance. Although there is government-subsidised transitional housing for asylum seekers, they may find the process too complicated or receive only limited benefits from the program. For example, asylum seekers applying for transitional housing are required to provide a plan for exit, which is often difficult for those with no secure employment or income.[495] Funding for more accessible and affordable housing for

asylum seekers that allows them longer residence until a decision is made about their refugee application can facilitate this population's resettlement and reduce their stress.

Caseworkers play an important role in facilitating successful resettlement for asylum seekers. However, Earnest et al. (2015) found that the large proportion of humanitarian entrants to Australia, in particular IMAs, resulted in a shortage of caseworkers leading to reduced support for this vulnerable population. Earnest et al. (2015) believe that the government offers under-resourced supportive services to asylum seekers, including caseworkers, as a punishing strategy to this population.[475] Availability of caseworkers, who compassionately work with vulnerable populations, can take some pressure off asylum seekers by providing financial, informational, and emotional support.

To decrease or avoid the risk of cultural incongruity and resulting conflicts within families and in the wider society, informational sessions should be provided to asylum seekers during their early years of settlement in the society. Provision of gender-specific supportive resources for asylum seeker women from traditional and patriarchal societies would be helpful. This support can be in form of informational services to orient women about the dominant culture in Australia and their rights within their families and society. In addition, these women need to be empowered through study and employment to gradually gain self-esteem and develop their self-identity to plan and pursue their life goals. Educating male asylum seekers from patriarchal societies about the norms of Australian society and women's rights is likely to help reduce conflict within families, and alleviate the resultant psychological stress.

9.3 Implications for clinical practice

This qualitative study revealed that some barriers, including language, cultural incompetency of healthcare providers, and lack of health literacy, affect asylum seekers' satisfaction with Australia's healthcare system. The study found the barriers hindered access and use of healthcare services by asylum seekers; as a result, their health needs may remain unmet with exacerbation of health issues. Untreated health issues can lead to an increase in the cost of healthcare by shifting from preventive and primary care to specialist care and an increased need for administration to manage these cases and provide necessary treatment regimens.[468]

The findings of this study suggest that timely access to healthcare services should be enabled by providing casework support for asylum seekers. Strategies should be applied to facilitate equity in access to primary, allied, and specialist health services. Furthermore, due to the greater need of asylum seekers for supportive health resources, this population should have continuous access to Medicare. Asylum seekers also should be eligible for the PBS and a wide range of health and welfare services, including healthcare cards to help in affording medications and subsequent adherence to treatment.

Mental health issues were found the most common reason for seeking health services by the asylum seeker women in this study. Adverse life experiences prior to migration, during transit and post-migration place asylum seekers at significantly higher risk of developing mental health disorders and in need of mental health intervention programs.[496] Lack of effective interactions with healthcare providers, in particular psychological counsellors, was a common experience. While NSW STARTTS offers culturally competent services and counsellors who speak Farsi/Persian,[497] some participants in this study were referred to counsellors from diverse cultures and languages. Ready access to

culturally and linguistically competent mental health providers is needed to improve mental health outcomes for individuals from diverse language and cultural backgrounds. Familiarity with asylum seekers' culture and background and previous experiences helps in the delivery of practical and more effective care. It can enhance patient-provider communication, which helps the provider gain a deeper understanding of the patient's concerns and improves the patient's trust in their care provider.[15] These elements are particularly important to improve the mental health outcomes for asylum seekers who often go through considerable adverse events during different phases of immigration.

In this study, lack of awareness of the women of the healthcare system of Australia and its challenges resulted in the women perceiving a delay in care provision as ignorance and discriminatory behaviour from healthcare providers, which increased their dissatisfaction with healthcare services. Increasing awareness of the asylum seekers about the healthcare system in Australia can reduce misunderstandings and misconceptions when using healthcare services. This may be realised through collaborative work between asylum seeker serving agencies, such as Settlement Services International, Asylum Seekers Centre, NSW STARTTS, and the Refugee Council of Australia. Literacy profiles and training should be provided in a range of different languages to benefit all asylum seekers residing in Australia.

9.4 Implications for future research

The current study provided valuable insight into the socio-cultural and health needs of Iranian asylum seeker women in Australia. The challenges over the years of resettlement in Australia were influenced by their life experiences prior to migration and during transit. However, adverse immigration policies were found to have tremendous negative effects on settlement of this population, bringing about a wide range of stressors for the asylum

seekers, including insure residence, instability, housing issues, financial difficulties, social stigma, discrimination, and social exclusion. Living in a limbo condition for an undetermined time in the destination country led to loss of significant personal, material, and social resources of these people, which could have been used to resettle in the host country. These conditions placed the women in a vicious cycle and led to further losses, such as suffering from mental health problems. The participants strived to control their stress and develop resilience towards their ongoing post-migration challenges through application of both emotion-focused and problem-focused coping strategies.

Future research could benefit from comparing men and women in terms of their perception of migration-related difficulties, their integration issues, and the heath impact of these experiences to understand gender-related experiences, and socio-cultural and health needs. The current study addressed the experiences of the asylum seekers within the early phases of settlement – two to three years after entry to Australia. Longitudinal research is recommended to explore the long-term impacts of migration-related experiences on these people's health and integration, as well as the role of facilitators, barriers, coping strategies, and resilience factors. Comparing social and cultural experiences and health outcomes of these asylum seekers with other immigrants who kicked off their post-migration experiences with secure residency status can yield a deeper understanding of the impact of insecure residency status on this particularly disadvantaged immigrant group.

Quantitative studies can examine the relationship between the duration of detention and short and long-term psychological harm. Appropriately designed quantitative studies can also investigate the relationship between experiences of post-migration constraints and difficulties and asylum seekers' health. Findings can help to identify the significant

factors and provide practical recommendations to minimise adverse effects on mental health.

The study focused on exploring the experiences of Iranian asylum seeker women to identify their social, cultural, health needs. Future research can benefit from conducting interviews with authorities, policy makers, or consultants dealing with asylum seekers to provide a more comprehensive understanding of the existing problems and challenges.

Consistent with the past research,[345] the findings suggest that coping strategies and resilience factors were important in enabling asylum seekers' access and use of resources to regain lost resources or gain new resources, which in turn positively affected their settlement and mental health. While the RBM acknowledges the role of resource replacement and resource substitution in adaptation to the host country, the model overlooks the importance of individual coping strategies in building resilience amongst immigrants. The addition of coping strategies and resilience factors as personal resources to the RBM may improve the applicability of the model.

Lastly, through the conduction of this research, the researcher, herself, gained a great deal of insight into the needs and ongoing difficulties of the participants of this study, who arrived Australia by boat. It was inspiring to learn how these people strive and use their limited resources to develop strategies to overcome the barriers and adjust themselves to a society that is different from their home country in many ways. Previous research on refugees and asylum seekers has mainly focused on describing refugees and asylum seekers' current challenges and needs. While this is important, attention to this population's pre-immigration and transit experiences can provide a deeper understanding of their existing problems, expectations, goals, and the resources that have lost or gained. The researcher believes that this is understanding is essential for developing programs to

target these people's needs and meet their goals, and a definite component of these programs should be counselling services and mental health interventions. As an immigrant who has experienced at least part of the challenges of the study participants and developed a deeper insight into the social, cultural, health issues of this population through this research, the researcher intends to continue her research on this filed, become an a voice to this vulnerable population group by widely disseminating her research findings in conferences, and engage in advocacy or policy activities for refugees and asylum seekers.

Appendix 1: People in immigration detention facilities as at 31 December 2013

Nationalities	Adult		Child (<18 years)		Total
	Male	Female	Male	Female	
Iran	972	430	207	145	1,754
Sri Lanka	692	127	97	58	974
Vietnam	470	89	71	38	668
Afghanistan	326	8	41	9	384
Pakistan	314	12	16	6	348
Iraq	30	30	30	20	284
China	69	21	0	0	90
Bangladesh	103	1	0	0	104
Indonesia	39	20	0	3	62
Myanmar	19	6	7	10	42
Other	899	243	139	131	1412
Total	4,107	987	608	420	6,122

Source: Department of Home affairs. Immigration Detention and Community Statistics Summary-31 December 2013. Available at: https://www.homeaffairs.gov.au/research-and-stats/files/immigration-detention-statistics-dec2013.pdf. Accessed June 18, 2018.

Appendix 2: People in immigration detention facilities as at 31 December 2014

Nationalities	Adult		Child (<18 years)		Total
	Male	Female	Male	Female	
Iran	481	173	2104	70	828
Stateless	167	49	54	50	320
Sri Lanka	164	22	11	9	206
Vietnam	135	17	5	10	167
Afghanistan	132	8	16	5	161
China	109	33	1	0	143
Pakistan	109	2	5	1	117
Iraq	77	13	12	12	114
Malaysia	56	21	1	1	79
Other	480	89	26	27	622
Total	1,910	427	235	185	2,757

Source: Department of Home affairs. Immigration Detention and Community Statistics Summary-31 December 2014. Available at: https://www.homeaffairs.gov.au/research-and-stats/files/immigration-detention-statistics-dec2013.pdf. Accessed June 10, 2017

Appendix 3: People in immigration detention facilities at 31 December 2016

Nationalities	Adult		Child (<18 years)		Total
	Male	Female	Male	Female	
New Zealand	178	6	0	0	184
Iran	113	15	<5	0	129
Vietnam	119	8	05	0	127
Sri Lanka	86	0	0	0	0
China	54	7	0	0	61
India	50	<5	0	0	52
Iraq	49	<5	0	0	51
Afghanistan	49	0	0	0	49
United Kingdom	42	<5	0	0	46
Other	534	44	<5	0	579
Total	1,247	88	<5	0	1,364

Source: Department of Home affairs. Immigration Detention and Community Statistics Summary-31 December 2016. Available at: https://www.homeaffairs.gov.au/research-and-stats/files/immigration-detention-statistics-31-dec-2016.pdf. Accessed March 18, 2017.

Appendix 4: People in community under residence determination at 31 December 2016

Nationalities	Adult		Child (<18 years)		Total
	Male	Female	Male	Female	
Iran	88	78	50	39	255
Sri Lanka	24	20	29	15	88
Stateless	17	13	11	16	57
Iraq	12	7	9	9	37
Vietnam	12	9	9	6	36
Other	28	24	28	13	93
Total	181	151	136	98	566

Source: Department of Home affairs. Immigration Detention and Community Statistics Summary-31 December 2016. Available at: https://www.homeaffairs.gov.au/research-and-stats/files/immigration-detention-statistics-31-dec-2016.pdf. Accessed March 18, 2017.

Appendix 5: Health and socio-cultural experiences of refugee women: An integrative review

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REVIEW PAPER

Health and Socio-Cultural Experiences of Refugee Women: An Integrative Review

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Abstract Approximately half of the global refugee population are women, yet they remain largely understudied from the perspective of gender. The aim of this review was to investigate the impact of refugee women's resettlement and socio-cultural experiences on their health. This review also explored factors promoting resilience in refugee women. Eight databases were searched for peer-reviewed manuscripts published from 2005 to 2014. Grey literature was also reviewed. Data were extracted for population, data collection methods, data analysis, and findings. The Resource-Based Model was used as an overarching framework for data synthesis. Following the screening of titles and abstracts, 20 studies met the study inclusion criteria. Cultural factors, social and material factors, personal factors, and resilience factors were identified as main themes influencing the health of refugee women. Promotion of factors that enables resettlement is important in promoting the health and wellbeing of refugee women.

Keywords Health · Integrative review · Refugee women · Socio-cultural

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Key Points

What do we know?

- Refugee women are at greater risk of mental health problems, such as depression and anxiety, due to lack of social support, violence, poverty, adverse health conditions, and discrimination.
- As wives and/or mothers, women bear extra burdens in the process of immigration in order to support family members adjust to a new way of living and often undertake the role of protecting and upholding family values, culture, and beliefs.
- Refugee children and the elderly have been at the center of attention in health research; however, women remain an understudied refugee population.

What does this paper add?

- This review outlines specific issues facing refugee women. These issues can impact on their health and integration into host societies.
- Refugee women develop resilience strategies that help them mitigate adverse experiences associated with migration.
- The review incorporates a conceptual framework based on the Resource-Based Model and argues that the addition of resilience factors can lend a better explanation to immigrant population experiences.

Recommendations:

- Targeted policies and services are needed to support the capacity of communities empowering refugee women with social and cultural supports.
- Providing health information and services such as counselling can enable refugee women to

appropriately identify and seek professional help in a timely manner.
- Culturally and linguistically appropriate mental health support groups can provide a platform for refugee women to share their experiences and burdens and attain social support from individuals who share common experiences and challenges.
- Further qualitative studies are needed to explore new challenges that refugee women confront during resettlement and the ways to overcome barriers.

Introduction

In recent decades, the number of asylum seekers and refugees has risen dramatically worldwide because of war, political conflict, and oppression [1]. While an 'asylum seeker' is a person who has applied for refugee status under the 1951 Geneva Convention, a 'refugee' is a person whose application has been accepted [2]. The global number of refugees under the United Nation High Commissioner for Refugees' mandate (UNHCR) is estimated to be 11.1 million. Currently, the United States (USA), France, Uganda, Sweden, and Australia receive a large number of asylum seekers [3]. Recent conflict in the Middle East, particularly Syria, has created an outpouring of refugees, many of whom are women and children [4].

Refugees and asylum seekers have diverse experiences and reasons for leaving their home countries. While some people choose to migrate voluntarily, millions are forced to leave their countries of origin and resettle in other countries due to factors including war, famine, poverty, political unrest, fear of persecution, economic instability and natural disasters [5, 6]. Refugees and asylum seekers frequently leave their countries in haste without any preparation and with a hope to be able to return to their country of origin. Many have had "no time to say goodbyes" [7, 8].

Globally, about half of the refugee population consists of women [9]; yet, they often remain underrepresented in research and receive inadequate attention and support as a result of socio-cultural disadvantages and language barriers [10]. Over the last decade, a developing body of literature on refugee and immigrant women and their health needs has predominantly revolved around their reproductive and antenatal health [11, 12]. In general, studies have either not separated refugees from immigrants in their report or addressed the health experiences of refugees as a whole without gender differentiation. While refugee children and the elderly have drawn some attention, the health and socio-cultural experiences of refugee women are often overlooked.

Evidence suggests that refugees, and in particular women, are vulnerable to mental health issues [13–15]. They are reportedly at greater risk of post-traumatic stress disorder (PTSD), depression, and anxiety related to lack of social support, poverty, poor health conditions, and discrimination [16–18]. As wives and/or mothers, women bear extra burdens in the process of immigration in order to support family members to adjust to a new way of living and often undertake the role of protecting and upholding family values, culture, and beliefs [19].

Resettlement is particularly challenging for women due to their lower socioeconomic status [20]. For example, compared to men, language barriers more often impede women's access to education, employment opportunities, health care services and factors that can facilitate adjustment and adaptation [21, 22]. O'Mahony [23] calls for further research to explore the experiences of refugee women in pre-migration and post-migration stages in order to help identify their unique health concerns and social support needs. The authors of this review set out to analyze the relevant literature from the past decade to help understand refugee women's resettlement and socio-cultural experiences and the impact of these experiences on their health and overall wellbeing.

Methods

Eligibility Criteria

Peer-reviewed and grey literature published between 2005 and 2014 were included to reflect the contemporary contextual conditions for refugees and asylum seekers in host countries. Articles needed to focus on adult refugee women who left their country seeking asylum in other countries. Both quantitative and qualitative studies were included to help capture the various aspects of refugee women experiences. Articles were excluded if they did not focus on adult refugee women.

Search Strategy

A systematic search strategy was developed in consultation with a health librarian. Databases and search engines used were Medline, CINAHL, ProQuest, Academic Search Complete, Scopus, Informit, PsycINFO, Google Scholar, and Google. Search terms and keywords were 'refugee*', 'asylum seeker*', 'humanitarian', 'women', 'female', 'cultur*', 'social', and 'health'. Reference lists of included articles were also searched for relevant articles. Article titles and abstracts were reviewed by the first author who applied inclusion and exclusion criteria. If unclear, the full text of the articles was also reviewed. This integrative

review followed the Preferred Reporting Items for Systematic Review (PRISMA) guideline to ensure a systematic search. The PRISMA guideline is an established appraisal tool enabling researchers to perform practical and transparent literature searches and report on systematic reviews [24].

Methodological Assessment and Data Analysis

Quality of the relevant articles was assessed using the Critical Appraisal Skills Program (CASP) and the PRISMA tool. However, due to the lack of adequate high-quality studies addressing the aims of this review, low-quality studies were not excluded from the review. The first author reviewed the studies for research population, setting, method of data collection and analysis, and findings. Table 1 illustrates the key findings of included articles. Extracted data were independently reviewed by all authors to increase the rigor of the review, and dissensions were resolved through conversations among the authors.

The post-migration phase of the Resource-Based Model (RBM), which is a combination of Berry, Hobfoll, and Lazarus and Folkman's theories, was used as an organizing framework for this review and provided the structure for analysis and presentation of results [25]. While there are some similarities between the RBM and social determinants of health framework [26], the RBM focuses specifically on migrants' adaptation process and their psychological wellbeing. The RBM reflects the various resources immigrants use to meet their needs, goals and demands. The assumption is that when needs, goals and demands are met suitably by accessible resources, individuals are satisfied with their psychological health [25].

The findings of the included qualitative papers were read several times by the first author to derive direct analysis without a model or priori expectation. The primary findings were discussed by all authors to assure the trustworthiness of the derived themes and findings. Derived themes were then grouped under the main categories of RBM to provide an overview of refugee women's experiences and health issues.

Results

The literature search yielded 899 articles. Following the application of the study's inclusion and exclusion criteria and removal of duplicates, 25 articles remained for further review. Five articles were subsequently excluded because of the amalgamation of immigrants and refugees, and men and women in the reporting of results. The search process and article selection are depicted in Fig. 1. Of the included 20 articles (Table 1), the majority of the studies were qualitative (n = 12), followed by quantitative (n = 6) and mixed methods (n = 2).

Overall, four main categories were identified. These included: (1) cultural factors, (2) social and material factors, (3) personal factors and (4) resilience factors. The findings of this review are explained in greater detail in the following sections.

Cultural Factors

Lack of proficiency in the dominant language of the host country reduces refugee women's chance of sharing experiences and burdens, increasing the risk of low self-esteem, loneliness, and depression [27, 28]. Refugee women, consequently, can become socially isolated, a factor that can negatively affect their acculturation and resettlement process [29, 30]. In their exploratory study, Casimiro et al. (2007) assessed the impact of language proficiency on the process and length of resettlement time among refugee women in Australia. They found that the ability to communicate with others was a significant factor in securing a job, accessing education services and promoting personal autonomy. Although interpreter services are frequently available, their uptake and utilization are variable. Refugee women may not be willing to share their personal experiences with interpreters due to a fear of misinterpretation, exposure, long waiting times, and perceived impatience of interpreters [29].

Culture shock is a multidimensional stressful experience resulting from experiencing an unfamiliar lifestyle or contact with a different culture in a new environment [31, 32]. This is commonly experienced by refugee women and described as "dropping from the moon to the earth" [33]. In a study by McBrien (2011), refugee mothers were concerned about their ability to survive in the USA because of a lack of cultural intelligence. They were concerned about the extent of changes in their children's behavior and underlying cultural values. Refugee women were particularly apprehensive about their daughters being bullied at school or developing disrespectful habits [34].

Social and Material Factors

Having a secure job is a critical factor in mental health and wellbeing of refugees [23, 27, 29, 33, 35–37]. Being employed enables refugee women to enhance their health status, as well as increasing their social networks [27]. Nevertheless, employment is strongly linked to language competency. The ability to communicate efficiently is considered a critical factor in recruitment [27, 28].

Furthermore, refugee women face many challenges in securing safe and affordable housing. Difficulty in obtaining housing is a post-migration stressor that hinders

Table 1 Summary of selected articles by first author, country, and aim of study, sampling method, instruments, main results, and type of study

Author	Country	Aim of study	Sampling method	Instruments	Main results	Type of study
Drummond et al. [60]	Australia	To determine whether highly stigmatized health problems create particular barriers for health care utilization in resettled refugees, and to ascertain whether age, level of education, or duration of resettlement might influence help-seeking pathways or barriers to health care	51 west African refugee women and 100 Australian women were recruited by invitation from the social network of eight west African survey administrators (African women) Undergraduate psychology students each recruited 12–15 female adults (Australian women)	Demographic questionnaire The questionnaire was part of a large survey initiated by a group of women from the West African community in Perth who were concerned about HIV and other disease spreading within their community	Barriers to access health care services: (West African refugee women) Interpersonal barriers (feeling too embarrassed or ashamed, afraid of others thinking, afraid of being judged, fear of losing their job or being hospitalized, pessimism, a sense of personal control).increasing years of residence in Australia contributed to increase the thinking about no money, no time, the distance to health care services Australian women: older less-educated women were more likely than younger more-educated women to approach a medical practitioner to manage stress Feeling ashamed or embarrassed, fear of other's thinking, fear of losing their job	Quantitative
Hashimoto and Rose [28]	Australia	to explore Sudanese refugee women's perceptions of the program and ongoing resettlement needs for future service development Abstract	12 adult women were recruited from an 8-week program at the Mamre Homestead	Group interview Interview questions were based around the exploring issues in resettlement to determine participant needs, including respite, language needs, employment and access	Key stressors raised include: Acculturation, housing difficulties, developing language skills, lack of employment opportunities and family separation	Qualitative

Table 1 continued

Author	Country	Aim of study	Sampling method	Instruments	Main results	Type of study
Casimiro et al. [29]	Australia	To explore resettlement issues of Muslim refugee women during their first five years of arrival	80 Muslim refugee women (35 Iraqi, 34 Sudanese and 11 Afghan) were recruited by purposive sampling	Semi-structured interviews Focus group with 30 participants Questions were based on the participants experiences over resettlements years and their needs	The main issues: English language competency (poor language was seen as a significant barrier to employment, feeling isolation, loneliness and depression) Economic and job security(lack of recognition of overseas qualifications, lack of financial resources to upgrade qualifications, discrimination, poor understanding of job network and lack of understanding of religious beliefs and practices) Gender and spousal influence Security and fear (media, racism and discrimination)	Qualitative
Schweitzer et al. [13]	Australia	To explore the impact of pre-migration trauma, post-migration living difficulties and social support on the current mental health of resettled Sudanese refugees	63 (21 female, 42 male) were recruited by Snowball sampling by bilingual community workers	Demographic and social characteristics The Harvard Trauma Questionnaire Hopkins Symptom Checklist Post-migration Living Difficulties	Social support leads to well-being mentally Support from ethnic community is the most important form of support Pre-migration trauma, family status and gender influence mental health outcomes	Quantitative
Keygnaert et al. [45]	Belgium and Netherlands	To explore the nature of sexual gender-based violence that refugees, asylum seekers and undocumented migrants experienced To discuss which perceived risk and preventive factors may be considered decisive determinants for the prevention of SGBV	223 participants (132 in Belgium, 91 in Netherlands) were recruited by purposive sampling	Questionnaire: Socio-demographic data(closed questions) Sexual health, personal or close peer SGBV experiences since arriving in Europe and prevention of SGBV (open questions)	Emotional-psychological violence leaded to isolation and depression Socio-economic violence leaded to loss of social support Physical violence leaded to permanently or temporarily injured, committing suicide Sexual violence leaded to HIV and sexual disorders, unwanted pregnancy, miscarriage	Mixed

Table 1 continued

Author	Country	Aim of study	Sampling method	Instruments	Main results	Type of study
O'Mahony and Donnelly [23]	Canada	To explore how cultural, social, political, historical and economic factors intersect with race, gender and class to influence the ways in which immigrant and refugee women seek help to manage PPD	30 women (8 refugees and 22 immigrants) were recruited by Purposive sampling	In-depth interviews Semi-structured questions The questions address: how do socio-cultural, political, historical and economic factors influence refugee women's mental health? And what services or strategies could address mental disorders?	Immigration status(unable to work, limited access to health care services, low income, no access to language classes and housing, family separation, insecure immigration status, fear of returning) affects their emotional well-being and self-esteem Precarious immigration status leads to vulnerability regarding to sexual, physical and economic exploitation Dependency on third person may leave women with limited access to information about their rights, at risk for domestic abuse, socially isolated and plagued with overwhelming fears of being deported and separated from their infant Shifting roles within the family (stay at home) leads to PPD	Qualitative
Schubert [18]	Finland	To examine the role of culture, refugee status and gender in the mental and somatic health among help seekers in a centre for torture survivors in Finland	78 adults (29 women, 49 men) were recruited by sequential sampling of patients who had appointment with the staff in the Helsinki Deaconess Institutes' Centre for Torture Survivors in Finland	Impact of Event Scale-Revised (PTSD) Hopkins Symptom checklist-25 (Depressive and anxiety) Patient chart information(somatic complaints) Harvard Trauma questionnaire (Exposure to trauma)	There are no significant main effects of the legal status on symptoms of PTSD, depressive and anxiety Gender is a significant covariance for PTSD	Quantitative
Tappis et al. [37]	Syria	To assess a variety of health and well-being measures among the Iraqi population in Syria	486 adult women recruited by Stratified cluster sampling	A household questionnaire One-page form of domestic violence (physical, verbal and emotional abuse)	Verbal abuse was the most common form (56 %) Physical violence (34 %) and emotional abuse (20 %) Women reporting some financial difficulties during the first month after arrival in Syria were 68 % less likely to have recently experienced violence than women who reported being financially comfortable upon arrival	Quantitative

Table 1 continued

Author	Country	Aim of study	Sampling method	Instruments	Main results	Type of study
Whittaker et al. [41]	The United Kingdom	To explore how young Somali female asylum-seekers and refugees, growing-up in northern England (a white, western host culture) understand psychological well-being To explore their individual and interpersonal or collective perceptions	Five adult women recruited from a voluntary sector Somali training and community centre in northern England	Three focus groups Five individual interviews	Supporting resources: Family and community, religion and services Socio-cultural problems: Conflicts and convergence, navigation and acculturation Concealment: Concealing concepts and emotions, secrets, confidentiality and trust	Qualitative
Catolico [43]	The United States	To define health from the perspective of Cambodian women in the context of resettlement To identify the conditions or circumstances that influenced their perception of health	39 refugee women in various ages were recruited from Community contacts by snowball sampling	Open ended questions The question addressed the perceptions of health of Cambodian women in resettlement	Strategies of coping: Achieving spiritual fulfillment, reestablishing kinship, engaging in meaningful work Experiences: loss, leaving behind, work and family life Caring for oneself: following tradition and integration option Consequences: Disharmony and harmony	Qualitative
Perera et al. [36]	The United States	To assess differences in pre-migration, transit, and resettlement stressor exposure and post-traumatic stress disorder (PTSD) symptoms as a function of demographic characteristics (i.e., gender, ethnicity, age, time in United States) To examine the concurrent and longitudinal relations between stressor exposure and PTSD symptoms	437 refugees from Oromo and Somali (115 Somali women, 98 Oromo women) were recruited from two previous cross-sectional studies with purposive sampling and lengthy recruitment	The pre-migration stress scale was a 20-item scale The transit stress scale The resettlement stress scale consisted of 16 items The PTSD Checklist–Civilian Version 17 self-report items Open-ended question was about the most stressful events have been experienced during resettlement	Pre-migration, transit and resettlement stressors result in PTDS PTDS was more among men rather than women	Mixed

Table 1 continued

Author	Country	Aim of study	Sampling method	Instruments	Main results	Type of study
Baird [27]	The United States	To present a situation-specific theory of well-being in refugee women experiencing cultural transition	7–11 women in each focus group	Focus groups The questions were: how do Sudanese refugee women conceptualize wellbeing?; What do Sudanese refugee women identify that facilitates well-being during the resettlement transition?; and what do Sudanese refugee women identify that inhibits wellbeing during the resettlement transition	Three phases of cultural transition: separation, being between two (old and new) culture and integration lead to enhanced or diminished well-being Facilitators are: education, ethnic community support, religion and English language skills Inhibitors: divorce, lack of education, lack of language skills and conflict between law and traditional culture	Qualitative
Nilsson et al. [42]	The United States	To increase the understanding by interviewing Somali mothers about the adjustment of Somali children	24 women 22–58 years of age were recruited from a local organization that serves refugee and immigrant women	Semi-structured and open-ended questions such as what do you see as the main problems facing you in your community? Demographic information	Women presented their experiences in five themes: cultural comparison, concerns about children, parents' loss of disciplinary authority, available support and the future	Qualitative
McBrien [34]	The United States	To gain insight into Somali, Vietnamese and Iranian women's experiences with resettlement and school involvement	22 mothers (seven Vietnamese, seven Somali and eight Iranian) were selected after the first survey by HRF members (Health for refugees' families) purposefully	Focus group, Open-ended questions	Vietnamese mothers: language barrier, rape in camps, No discrimination, appropriate schools Somali mothers: language barrier, hardship in camps (inadequate food and education, danger and heat), taunting at school, English insufficiency leads to underestimating discrimination Iranian mothers: taunting at school, discrimination at work and school, language barriers, cultural barriers, free relationship between girls and boys, sexual permissiveness, illegal drug access	Qualitative

Table 1 continued

Author	Country	Aim of study	Sampling method	Instruments	Main results	Type of study
Brown et al. [47]	The United States	To explore the relations among selected demographic variables and three dimensions of mental health (general distress, somatic distress and performance distress)	83 adult women were recruited by purposive sampling from Vietnamese a community centre, a Vietnamese Buddhist temple and an international women's institute	The Hopkins Symptom Checklist-21 Demographic questionnaire (age of arrival, English proficiency, length of stay, income, relationship status, parenthood, education level, religious affiliation)	Poorer English proficiency leaded to grater general and somatic distress Women with older age of arrival reported greater somatic distress No relationship between income and mental health Women with more children and less-educated reported greater forgetfulness and worries about accurate and through task completion	Quantitative
Nilsson et al. [30]	The United States	To examine the relations among acculturation, domestic violence, and mental health in married refugee women from Somalia	62 married women were recruited through an organization that supports the adjustment of refugee and immigrant women	Hopkins Symptoms Checklist-21 Conflict Tactic Scale-2 Demographic information Acculturation (speaking English, time spent in the US and the number of American friends	Women with greater proficiency in speaking English were more likely to experience both psychological and physical abuse from their partners	Quantitative
Sossou et al. [32]	The United States	To focus on Bosnian refugee women's experiences as refugees and the factors that contributed to their resilience	Seven refugee women were recruited by purposive sampling by sending invitations to participants who attended the previous quantitative study	Face to face interviews Open-ended questions Questions addressed their general well-being before their flight from Bosnia; their families and children and their mental well-being; their spirituality and religion; and the challenges of resettlement in a new country	Personal experiences and challenges with resettlement consist of language barriers, lack of public transportation, lack of instant educational opportunities and misconceptions about accessing mental health services Shocking experiences consist of loss of occupational status, family disconnection and cultural changes in the new country Resilience factors included family and spirituality (not religion, belief in a higher power)	Qualitative

Table 1 continued

Author	Country	Aim of study	Sampling method	Instruments	Main results	Type of study
Carroll et al. [48]	The United States	To learn more about Somali women's health experiences in order to improve health care for Somali women	34 adult women were recruited by snowball sampling	In-depth interviews/one focus group consisted of six women Questions were around the Somali women's beliefs about health promotion; and what do Somali women know about common health services in the United States that detect or prevent disease	The important themes to be healthy: Hygiene and sanitation, adequate nutrition and exercise, Traditional health care networks, remedies and rituals, religion, access to health care and medications Knowledge about the U.S health care system Conceptual themes: Participants generally considered themselves healthy, focus on survival, good health as a key priority, improved opportunity for education, freedom	Qualitative
Pavlish [35]	The United States	To examine meaningful life experiences as narrated by women and men Congolese refugees residing in a refugee camp in Rwanda	29 adults (15 men and 14 women) were recruited by purposive sampling	In-depth interviews (two stages) Participants were asked to describe memories and anecdotes about significant events in their past and present lives	Prevalent themes that refugee women suffer from: Leaving the good life behind Worrying about their daughters Feeling ambivalent about marriage Lacking hope	Qualitative
Pavlish [40]	The United States	To describe a collaborative capacity building experience with refugee women	100 refugee women were recruited by purposive sampling	Three focus groups Questions were around the lived experience in the camp by "can you tell me more about that?" and "what do you mean by that?"	Poverty: the most significant issue that affects refugee women's health by leading their husbands to high-risk sexual behaviors Struggle to survive Overburden of family work Ambivalence of family planning Lack of freedom to express themselves	Qualitative

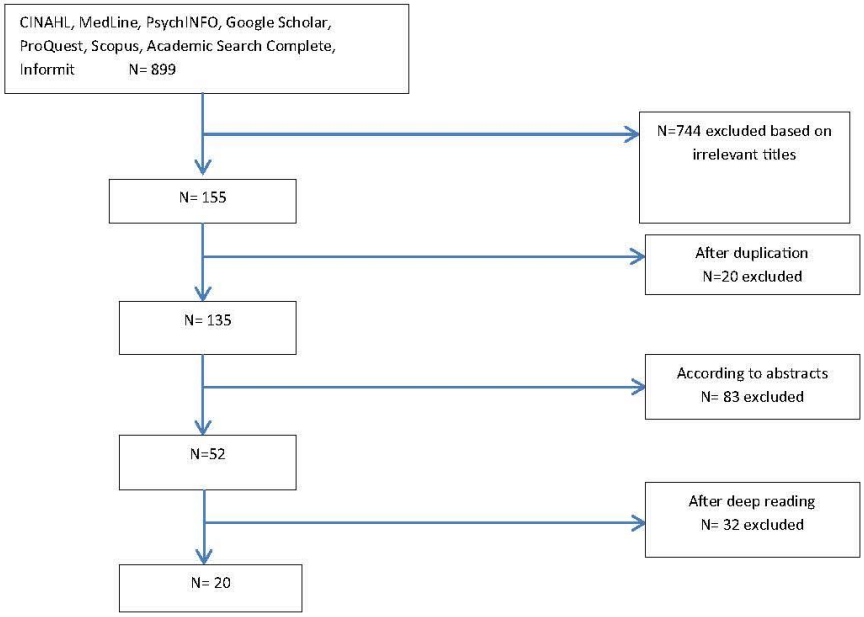

Fig. 1 PRISMA flow chart presenting the selection of studies

resettlement. Difficulties include the perception of realtors that refugee renters may not be able to pay the rent or that multiple children may damage properties [23, 28, 36, 38, 39]. Not having convenient and secure accommodation is a stressful resettlement experience that should not be neglected by health providers who aim to improve the health and wellbeing of refugee women [36].

Loss of social support from either family or husbands leaving refugee women may result in sadness, hopelessness, and poverty. These feelings may be aggravated by being abandoned by their husbands who seek to profit from more advantaged women in the host country [40].

Personal Factors

Family separation is another problem that confronts refugees. Many refugee women describe leaving behind family members in an unsettled situation as a "traumatic experience" [13, 23, 28, 33, 41, 42]. Uncertainty about the condition of family members who have been left behind is a key source of distress amongst refugee women [43]. This is seen as a major contributing factor to the experience of depression and other mental disorders [13, 22, 41, 42, 44]. In contrast, a united family is a factor that enhances and maintains relationships and family wellbeing [43].

Exploitation of young girls is another significant concern for refugee women. Many women in refugee camps report worrying about their daughters being involved in sex work. In a study of a refugee camp in Africa, mothers explained that although they could not afford it, their young daughters requested luxuries such as clothes and shoes to be accepted in the new society and "look smart", a need that may lead them to be involved in sex work. Alternatively, some women want to support their young daughters by undertaking extra work or being engaged in sex work themselves [35].

Collectively, these factors increase the risk of mental health problems among refugee women, making adjustment to new host countries particularly difficult for this group [13]. Some women may also lose their hope for a bright future. A study in the Congo found that refugee women attempted to improve circumstances only for their children and had no hope of a better future for themselves [35]. These adverse feelings can result in social isolation making some refugee women vulnerable to decision-making biases and the loss of successful social integration [40]. In contrast, Bosnian refugee women were optimistic and believed in a bright future for their children and themselves [33].

Resilience Factors

The review of the literature suggests that refugee women employ various strategies to cope with their new way of life. Spiritual fulfilment and social support are commonly used resilience strategies that help asylum seeker and

refugee women maintain equilibrium in spite of their uncertain status and ongoing distress [33]. Spirituality is defined as either non-religious spirituality which can contribute to coping with new situations and accompanying shocking experiences [33] such as loss of parental authority [42], loss of professional status [29], and family disconnection [33], or belief in a higher power which leads to a "sense of meaning", "purpose in life", and "wellbeing" [27]. "Standing on our legs" is a conceptualization used by some refugee women, giving them a sense of pride and empowerment, and leading to optimism, hope, and a sense of wellbeing [27].

Family and ethnic communities are additional supporting resources contributing to the wellbeing of refugee women and their integration into a new society. Ethnic communities support refugees by linking them to community and health services, which can ease the acculturation process for new arrivals [27]. These communities provide an opportunity for women to share their experiences and cultural values with their counterparts, alleviating the burden of distress [45]. Communities also provide support in the form of information and empower refugee women to deal more effectively with their existing concerns [27]. The social supports provided by ethnic communities are recognized as a critical predictor of refugees' mental health [13, 33, 45].

In addition, re-establishing kinship and ensuring family unity helps to mitigate adverse effects of immigration [43]. As such, refugee women who lack family resources may experience more vulnerability to mental health problems [41]. Apart from immediate family members, extended family and close friends have also been cited as important sources of support [41]. Making self-sacrifices for family has been reported as a resilience factor by some refugee women which can help strengthen their self-confidence, position in the family, and identity over the period of transition to a new life [33].

Discussion

This integrative review highlights individual and sociocultural difficulties that refugee women may encounter in the process of resettlement and the impact of these experiences on their health and wellbeing. The results of this review suggest that the circumstances surrounding resettlement may adversely affect the health of those who seek asylum and/or refuge, while adopting effective strategies helps mitigate these impacts.

In spite of refugee women's tendency to be integrated into new societies, an inability to communicate in the language of the host country may affect their successful integration [27, 28], as language competency is an important factor facilitating the resettlement process for this population group [29, 46]. This finding is also supported by a study that found that integration is easier for those who arrive at a younger age, possibly because language acquisition is considerably easier [47]. However, some studies have found that language barriers are not a critical constraint in the integration process of refugees [29, 48], and that prejudice and family breakdown are more significant barriers hindering the integration of refugee women [29, 48]. This inconsistency may relate to differences in study designs and needs further research. Language deficiency may also negatively affect refugee women's health by hindering them from accessing health care services including preventive screening such as mammography and cervical screening programs [48], although some believe that lack of information and "shyness" are more influential barriers [49]. There is a need for further research to identify barriers to health service access and use in particular population groups [50, 51].

Supporting refugee women to obtain affordable and good quality accommodation is another critical factor that can facilitate their successful resettlement and accelerate the integration process [52, 53]. Lack of a secure job [52] and stigma towards refugees [23] have been identified as the major obstacles to attaining safe and convenient housing. However, this seems to vary from place to place even within the same host country [52]. For example, if refugees are able to find a secure job in Montreal, they can also afford a convenient property, while the story is different in Vancouver and Toronto due to the high cost of accommodation, shortage of social housing, and racial discrimination. These findings, however, cannot be generalized due to small sample size and existent bias related to recruitment among a specific immigrant organization [52].

Separation from family as a personal resource exposes refugees to the risk of depression. While refugees' self-esteem, sense of mastery, and integration usually improve in host countries [54–56], the risk of depression seems to increase with the length of time away from close relatives [13]. The role of the intact family as a significant supporting resource in successful integration is important and has been considered in the RBM [25]. However, discrepancy between refugees' and Westerners' concepts of family makes it difficult for refugees to apply for family reunification. Refugees who are mostly from Eastern cultures, define family as people who are living together including extended family, not just parents, children and siblings. Once a great support resource, separation from immediate and/or extended family adds to the burden of stress increasing the risk of mental disorders such as depression in this population [57]. Understanding different cultural meanings of "family" and making changes towards reunification policies should be important

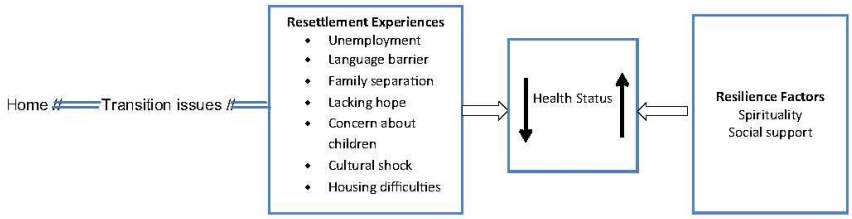

Fig. 2 Incorporated conceptual framework based on the Resource-Based Model

considerations for policy makers and care providers when developing evidence based and tailored supportive programs to help improve the health and wellbeing of refugees.

Providing health information and services such as counselling and educative workshops can enable refugee women to appropriately identify and seek professional help in a timely manner [58, 59]. Moreover, culturally and linguistically appropriate mental health discussion groups provide a platform for refugee women to share their experiences and burdens and attain social support from individuals who share common experiences and challenges [60].

While much of the literature on refugees has focused on adverse effects such as vulnerability and challenges, immigration can also bring about some positive changes for refugee women such as freedom, equity, and greater opportunities for education and work [56]. The negative experiences associated with immigration can be considered loss of resources that can induce further loss. For example, losing social status due to language deficiency begets further loss in refugees. This is referred to as "resource loss spiral" which can adversely impact on the mental health of refugees [25, 61].

Findings of this review lend support to the RBM. Resilience facilitators were also identified as important factors affecting the resettlement process and the health of refugees. These factors also need to be understood to provide a more comprehensive picture of immigrants' strengths and challenges (Fig. 2).

Resilience is a dynamic and multidimensional factor [62] which empowers refugee women to cope with a new situation through adapting as well as recovering from traumatic or stressful conditions [63]. While resource loss is a threat to mental health of this population group [64], understanding facilitators of resilience can help develop appropriate programs to prevent further health decline and improve overall health and wellbeing of refugees [65]. Resilience is an overlooked area of refugee research, including the RBM [66–68], but it is increasingly gaining attention [56, 69–71].

There are many studies that emphasize the significant role of resilience factors (spirituality and social support) on health and wellbeing [39, 65, 69, 70, 72], however, further research is needed to help resolve some existing controversial issues [69]. For example, while overall women seem to be more resilient than men, the rate of depression and anxiety is also higher amongst women [63]. Moreover, while many studies consider resilience as a protective factor that enables women to maintain or promote their health status [13, 27, 33, 45], hardly any research has focused on understanding how resilience mitigates the adverse resettlement experiences of refugee women [71].

Conclusion

The findings of this review suggest that cultural, social and material, and personal resources of refugee women are lost during the different phases of immigration [24]. Yet, helping refugee women to appropriately identify and apply culturally appropriate resilience facilitators can improve the health and experiences of this vulnerable population group. It is recommended that resilience factors be incorporated into the RBM to help depict a more complete picture of immigrants' challenges and resilience strategies. In addition, understanding refugee women's values, perspectives, and expectations and using this knowledge to inform immigration policy can help improve care and outcomes for refugee populations.

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Compliance with Ethical Standards

Conflict of interest The author(s) declare that they have no conflict of interest.

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Appendix 6: The impact of migration on the health status of Iranians: An integrative literature review

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The impact of migration on the health status of Iranians: an integrative literature review

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Abstract

Background: Immigration, both voluntary and forced, is driven by social, political and economic factors. Accordingly, some discussions and debates have emerged in recent years about the impact of migration on the health status of migrants. The aim of this review was to identify the impact of migration on the health status of Iranian immigrants and present a conceptual framework to facilitate the design and delivery of services and supports for this particular immigrant group.

Methods: Data for this integrative review were collected from Medline, PsycINFO, Scopus, ProQuest, Academic Search Complete, CINAHL, and Google Scholar search engine. The database search was limited to peer-reviewed literature, published in English, between 1980 and 2013.

Results: Twenty six articles were included in the review. Analysis revealed several factors influencing the mental health of immigrants, including language insufficiency; unemployment; sense of discrimination; cultural shock; lack of social support; lack of information about health care services; and intimate partner violence.

Conclusion: Findings of this review have contributed to development of a conceptual framework that delineates the impact of migration on Iranian immigrants' health. This conceptualization may also help in addressing the needs of other vulnerable groups during the transition phase of migration.

What do we know?

- Migration can be a stressful experience.

What does this paper add?

- This review outlines migration-related challenges that immigrants struggle with in order to integrate into host societies.
- Iranians' view of health is different from Western concepts of health. As a consequence, Iranians' socio-cultural values and beliefs should be taken into consideration in health care interactions.
- Despite negative effects, migration can have a positive impact on health and quality of life.
- Although immigrants may share similar experiences, social and cultural differences mean that Iranians may respond differently to migration challenges.

Recommendations

- Further research should explore the socio-cultural values and challenges of migrants in host countries and examine how these affect mental health.
- Additional emphasis should be placed on understanding perspectives of vulnerable populations, such as refugee children, women, and the elderly.
- Using a strengths and resilience-based approach may be useful in intervention development.

Introduction

Immigration, whether voluntary or forced, is increasingly driven by social, political and economic factors. As a consequence, some discussions and debates have emerged on the impact of migration on health status of immigrants [1, 2]. For generations, people have left their homelands and resettled in other countries seeking better future [3]. Such transitions can be challenging and may contribute to social marginalization, loss of social networks [4–6], health care access issues [7], and adverse health consequences,

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including depression and anxiety [8–11]. Not only do immigrants face challenges adapting to their new country, but many also continue to be impacted by the process of immigration, events that precipitated their departure, and ongoing relationships with friends and relatives in their home countries [12]. For example, events such as the Islamic revolution, political changes, war, and sanctions from the United States of America (USA) have compelled many Iranians to flee their homeland over the last thirty years [13, 14]. As a result, Iranians comprise a significant proportion of immigrants departing from the Middle East [14–18]. For example, the number of Iranian immigrants in Canada indicates a growth rate of 147 % from 1996 to 2006 [19]. In addition, Iranians can be found throughout the world such as Australia, Europe, Canada and Asia [20].

The increasing trends in migration worldwide have provided the impetus for focusing on the processes and outcomes of immigration. Yet, to date, there is limited research and information available that describes Iranian immigrants' health status and migration outcomes [1, 2, 14, 21]. The available evidence suggests that Iranian immigrants are at risk of mental health problems. For example, the results of a study in Germany showed that 28 % of Iranian immigrants were suffering from mental disorders associated with acculturation stress [22], but further understanding of factors involved in succumbing to or preventing acculturation stress is unavailable. Without such an understanding, the needs of this group will remain unmet, leaving them vulnerable to adverse health and wellbeing outcomes in their new homelands.

Our aim in conducting this review was to ascertain information about Iranian immigrants' resettlement experiences and health outcomes for the purpose of informing design and delivery of services and supports to prevent and reduce adverse effects of immigration. Although there has been much written about health outcomes of immigrants, this review will contribute the unique contextual experiences relevant to Iranian immigrants.

Methods

Search strategy

The search strategy was designed in consultation with a health librarian. Electronic databases searched were Medline, CINAHL, ProQuest, Academic Search Complete, Scopus, PsycINFO, and the Google Scholar search engine. Reference lists of the relevant literature were also reviewed for further related studies. Keywords used in the search were terms that depicted the person or event of migration (immigra* migrant*, emigrant*, exil*, refugee*), the target population (Iran*, Persia*) and health-related outcomes (health experience, health issue, health problem, mental health, psychological, mental problems).

Selection of studies

Articles were included if they were written in English and published after 1980. This date was selected as it paralleled the first major wave of Iranian migration [14]. The review included studies of any design, involving adults (aged 18 years and over) who were Iranian immigrants departing their country for any reason, voluntary or forced and were settled in a host country. Articles were excluded if they did not focus on Iranian adult immigrants. Articles that focused on people from different nations were also included if they reported Iranians' experiences separately when describing the results. Articles that focused on physical health issues without any consideration of the influence of immigration were excluded. This integrative review was guided by the principles of the Preferred Reporting Items for Systematic Review (PRISMA) [23]. Titles and abstracts of retrieved studies were reviewed to assess whether they met inclusion criteria. If inclusion was not immediately clear, full texts of articles were retrieved and reviewed.

Data management and extraction

The first author extracted data from articles that met inclusion criteria and inserted information regarding aims, study design, sample size, geographic region of settlement, and outcomes into an excel spreadsheet to allow for tabulation and comparison across studies. A summary table was used to depict key themes and findings of included articles (Table 1). Discussions regarding data extraction were performed independently by two authors (SS-MD, SS-LG). Any disagreements were resolved through discussions until consensus reached.

Methodological assessment and data analysis

The first author assessed quality of the included articles using Critical Appraisal Skills Program (CASP). The studies were separated into qualitative, quantitative and mixed-method studies. A general inductive analysis approach was used to derive themes from the findings. Where multiple nationalities were included, results depicting only Iranian participants were extracted. Extracted themes and inconsistencies were discussed among the authors.

Results

Following application of inclusion and exclusion criteria and removal of duplicates, 26 articles were included in the review (Fig. 1). Of these, sixteen studies were quantitative, nine were qualitative and two used mixed-methods (Table 1). Data collection methods included focus groups and interviews with Iranian immigrants, cross-sectional surveys, and randomised control trials. Qualitative studies depicted the experiences and their relationship with immigrants' health status. Quantitative studies mainly centred on prevalence of negative experiences and

Table 1 Included articles depicting Iranian immigrant studies

Author (year, Country)	Aim of study	Samples	Instruments	Main results	Type of study
Alizade-khoie 2011 Australia	To explore the impact of acculturation on health status	*N* = 302 Iranians Age > 65 y	Developed questionnaire from the NSW Older People's Health Survey 1999	• Iranian elderly immigrants suffer from high level psychological issues and physical activity limitation • English proficiency decreases the rate of depression and anxiety	Quantitative
Khavarpour 1997 [25] Australia	To determine the levels and predictors of psychological distress within the Iranians living in Sydney	*N* = 161 Iranians	General Health Questionnaire (GHQ-20)	• Students more likely to report psychological distress compared to full-time workers • migration contributes to psychological distress • social support can reduce the experience of distress of unemployment and poor English proficiency	Quantitative
Steel et al. 2011 [27] Australia	To examine for differences in the trajectory of psychological symptoms and key indices of social adaptation amongst refugees over two years	*N* = 104 Iranian and Afghan immigrant	• The Harvard trauma questionnaire • The Hopkins symptom checklist-25 • The general health questionnaire • The Penn State Worry questionnaire • Post-migration living difficulties and detention experiences checklist	• Language insufficiency results in increasing mental distress, social isolation, difficulty in acculturation process, and on-going resettlement difficulties	Quantitative
Neale 2007 [33] Australia	To examine the knowledge, use and satisfaction of local health care services	*N* = 98 Iranians, Afghan and Iraqi *N* = 23 Iranians	• Semi structured questionnaire • focus group • multiple-choice questionnaire •open-ended questionnaire	• poor English proficiency = dissatisfaction from health care services	Qualitative
Jafari 2010 [14] Canada	To examine the impact of immigration on mental health	*N* = 44 Iranians	• Focus group • In-depth review	• Low English proficiency resulted in social isolation, anxiety, mental problems, joblessness and unstable and aggressive behaviours	Qualitative
Dastjerdi 2012 [3] Canada	To identify the obstacles and issues that Iranian immigrants face to access to health care services through the lens of Iranian health care providers	*N* = 50 Iranian immigrant who work as health providers	• in-depth semi-structured individual interviews • three focus groups • Narrative inquiry	• Language barrier and lack of knowledge of Canadian health care systems. • Lack of trust in Canadian health care services due to financial limitations and fear of disclosure	Qualitative
Dastjerdi 2012 [15] Canada	To explore the Process of access to Health care services	*N* = 17 Iranians	• Individual face to face interview with a broad question then focused on health-relate experiences • Telling story	• Getting isolated as a result of poor English skill • Tackling obstacles and being integrated	Qualitative

Table 1 Included articles depicting Iranian immigrant studies (*Continued*)

Dossa 2002 [31] Canada	To explore the pedagogical potential of stories of post revolution Iranian women living in Canada	*N* = 40 Iranian women	• Semi structured interview • two focus groups • Story telling	• Iranians experience discrimination • Iranians experience depression • language barriers can result in unemployment or underemployment	Qualitative
Tyndale et al. 2007 Canada	To explore the needs and experiences of Iranian immigrants about sexual health	*N* = 20 Iranians	• Semi structured interview	• difficulty in adjusting with new culture where sexuality is a usual fact • difficulties in receiving sexual health care because of misunderstanding (culture diversity) and shame and modesty	Qualitative
Guruge 2012 [38] Canada	To examine the relationship of violence and physical and mental health	*N* = 30 Iranian women	• Brief symptom Inventory • Harvard trauma Questionnaire	• about one third of Iranian immigrant women suffer from mental illness because of intimate partner violence	Quantitative
Ebrahimian 2012 Canada	To examine the effects of immigration on mental health of the Iranian immigrants residing in Toronto by comparing them to their counterparts in Iran	*N* = 200 Iranians	• Demographic questionnaire • Depression Scale	• The rate of depression is higher amongst elderlies then younger immigrants • highly educated immigrants are less depressed than low-educated ones	Quantitative
Singhammer 2011 [26] Denmark	To explore the relationship of violence and mental health among Iranian immigrants	*N* = 991 Iranian women	• A questionnaire including health indicators, health risk factors, healthy behaviours & health care services	• Iranian women had the greatest rate of divorce among other ethnic minorities in Denmark • The rate of violence was reported higher amongst Iranian women than other minorities	Quantitative
Lipsicas et al. 2012 [4] European countries	To compare the frequencies of attempted suicide among immigrants and their hosts, between different immigrant groups, and between immigrants and their	*N* = 4160 immigrants from various countries included Iran	• Data were obtained from the WHO/EURO Multi-centre Study on Suicidal Behaviour	• Iranians displayed high suicide attempt rate in European countries despite low suicide rates in Iran • Immigration process in itself and the difficulties in acculturation can result in high- suicide attempt rates	Quantitative
Haasen et al. 2008 [22] Germany	To find evidence for a relationship between acculturation stress and mental health problems, mainly depressive symptomatology	*N* = 100 Iranians	• Acculturation-stress-index (ASI) • SCL-90-R • Hamilton Depression scale (HAM-D)	• 28 % of Iranian immigrants suffer from mental disorders without treatment • Depression score was high amongst Iranian immigrant • Inaccessibility of mental care centres	Quantitative
Gerritsen et al. 2006 Netherlands	To estimate the prevalence rates of physical and mental health	*N* = 410 Iranians, Afghan and Somali *N* = 117 Iranians	• medical outcome study (MOS) • SF-36 • Harvard trauma questionnaire • HSCL-25	• 43.4 % of Iranian asylum seekers suffer from depression and anxiety • Iranians suffer from dental and eye problems, back pain, neck/shoulder complaints, headache	Quantitative

Table 1 Included articles depicting Iranian immigrant studies *(Continued)*

Akhavan 2007 [24] Sweden	To analyse females' perceptions of various factors that influence their health	*N* = 10 Iranian women	• Semi-structured interview	• Discrimination is the greatest threat for health • Unemployment and financial issues result is mental problems • Domestic violence, depression, and divorce as immigration adverse effects	Qualitative
Bayard 2001 [34] Sweden	To examine the association between ethnicity among migrants born in Iran and psychiatric illness and intake of psychotropic drugs	*N* = 1980 Iranian, Kurd, Turkish, Polish, Chilean *N* = 293 Iranians	• Swedish Survey of Living Conditions questionnaire plus immigrant specific questions • Face to face interview	• Iranian had more risk of mental illness and intake drugs 6 and 5fold more than swedes respectively. • Feeling discrimination by Iranians was higher than other ethnic minorities	Mixed(Qualitative and Quantitative)
Momeni et al. 2011 Sweden	To investigate the self-reported mental health among two Iranian groups; in Sweden and Iran	*N* = 208 Iranians	• An author-made questionnaire	• 21 % of elder Iranian immigrants suffer from depression same as their counterparts in Iran • depression rate was higher among Iranian women compared to men	Quantitative
Tinghog et al. 2010 Sweden	To investigate the association of immigrant and non-immigrant-specific factors with mental ill health within a diverse immigrant population	*N* = 720 from Iran, Iraq and Finland *N* = 250 Iranians	• The Hopkins symptom checklist-25 • The WHO (World Health Organization) Well-being Index	• 48 % of Iranian immigrants suffer from depression • 19 % of Iranian immigrants suffer from discrimination • Unemployment and poor social network can lead to depression • being female is a risk factor for mental disorders	Quantitative
Wiking 2004 [36] Sweden	To analyse the association between ethnicity and poor health	*N* = 2160 From Poland, Iran and Turkey *N* = 480 Iranians	• Standardized & translated questionnaire for assessing the socioeconomic status (SES)	• Discrimination and acculturation are two important mediators between ethnicity and health. • High discrimination is felt by 34 % & 51 %, respectively, by men and women • 41 % of women reported poor health status	Quantitative
Lipson 1992 [28] The United States	To examine the immigration experiences of a sample of Iranians in the USA	*N* = 35 Iranians	• Semi-structured interview • Health opinion survey (HOS)	• Lack of social support • Communication problems because of language insufficiency • culture shock • difficulty to find a good job • Financial problems • Ethnic bias (discrimination)	Mixed(Qualitative and Quantitative)

Table 1 Included articles depicting Iranian immigrant studies *(Continued)*

Martin 2012 [37] The United States	To explore elderlies' experience of discrimination in American health care system	*N* = 15 Iranians	• In-depth interview (in person) • Open ended questions	• There was no discrimination • Highly positive impression of American health care providers • Language barrier as a factor for underestimating possible discrimination	Qualitative
Meleis et al. 1992 The United States	To investigate the nature of the relationship between demographic characteristics, ethnicity, length of time in the USA and physical and mental health/illness status, psychological well-being, and perceived health	*N* = 88 Egyptian, Yemeni, Iranian, Armenian, and Arab immigrant *N* = 16 Iranians	• Socio-demographic questionnaire • Ethnic identity questionnaire • 10-point rating scale • Cornell Medical Index (CMI) • Revised Bradburn Morale Scale • 10-point Cantril ladder scale	• unavailability of an ethnic community in overseas can result in depression and isolation among elderlies • Iranians usually enjoy from high integration and assimilation in host countries • integration increases along with increasing the length of stay in the host country • increasing the length of stay in the host country doesn't improve the immigrants' health situation	Quantitative
Saechao et al. 2012 [29] The United States	To examine stressors and barriers to using mental health services among first-generation	*N* = 30 from Cambodia, Iran, Iraq, Vietnam, Africa, eastern European *N* = 4 Iranians	• Six focus groups	• Barriers: Language, cost, lack of information about mental health services • Stressors: discrimination, economic status, difficulty to find suitable job	Qualitative
Ghaffarian 1998 The United States	To explore the relationship of acculturation and mental health	*N* = 238 Iranians	A five section questionnaire including: • Demographic Questions • Warheit & Buhl's Anxiety, depression and Psychological dysfunction scale • Iranian version of Mendoza 's Cultural Life Style Inventory	• Acculturation increased = score of mental health decreased (better) • Men are healthier than women mentally	Quantitative
Ghaffarian 1987 The United States	To examine Iranian immigrants, their acculturation to the American culture, and specifically, the acculturative differences between males and females	*N* = 110 Iranians	• Demographic Questionnaire • Warheit & Buhl's Anxiety scale • Traditional family ideology designed by Levinson and Huffman (1955) • Acculturation scale designed by Cuellar, Harris, and Jasso (1980)	• Less adjustment to host culture = stress and depression • Men are more able to adjust themselves with new societies and cultures	Quantitative

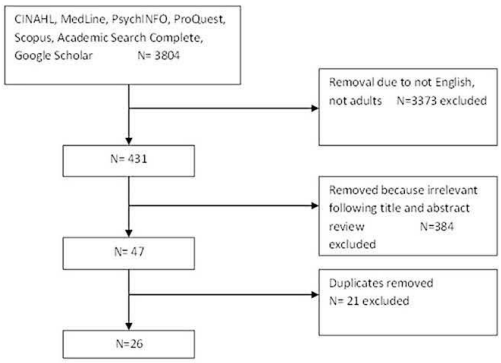

Fig. 1 PRISMA flow chart depicting study selection

their association with mental disorders. All included studies were conducted in Western countries such as Sweden, Canada, and the USA. Themes derived from the articles reflected the socio-cultural lens of migration in respect of phases of transition: including pre-migration, migration and post-migration (Fig. 2).

Qualitative studies

Data were collected through face-to-face interviews and focus groups. Importantly, maintaining anonymity and confidentiality were paramount ethical considerations involved in conducting research with these populations. Audio recording was refused by participants in one study because of their previous experiences of information gathering for political purposes and resultant distrust [24]. Despite such risks, only eleven studies out of 26 provided explicit statements regarding ethical considerations.

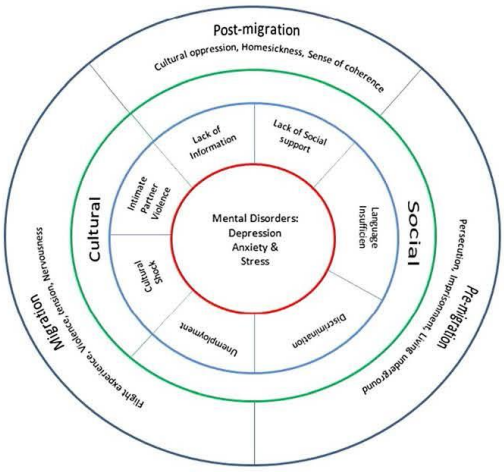

Fig. 2 Framework of concepts pertinent to Iranian immigrant experiences

Quantitative studies

Cross-sectional data were collected predominantly *via* close-ended questionnaires administered *via* face-to-face interviews. Two studies asked respondents to complete questionnaires using web-based survey platforms or *via* telephone interview [25, 26].

Findings of the included studies revealed seven sub-themes under two main categories of social and cultural issues, that represent common problems faced by Iranian immigrants during and after immigration and throughout the settlement process. The main themes and associated sub-themes are presented in Fig. 2 and explained in the following section.

Social issues

Language barriers

Learning the host country language is an important factor in social engagement. It seems that inability to understand English affects all aspects of Iranian immigrant life. Poor language skills has been related to communication difficulties, protracted resettlement and acculturation processes, and mental distress [27]. The adverse experiences may contribute to social isolation, anxiety and depression [3, 27]. Just as language proficiency can affect immigrants' health, immigrants' wellbeing can influence their language acquisition. Impaired mental health can challenge one's adjustment and language acquisition [27]. Steel et al.'s study [27] found that refugees with permanent protection visas had higher language acquisition compared to refugees with temporary protection visas [27]. Participants with temporary protection visas showed no significant improvement in their language skills over time, leading to increase the rate of mental distress, depression, and social isolation in this population. In contrast, those with permanent protection visas demonstrated a significant improvement in their language ability, engaged in social activities, and integrated well into the host society [27]. Together, these data exhibit a pattern of increased mental distress amongst immigrants with low levels of host language proficiency.

Employment

Inability to find employment commensurate with qualifications was identified as an important stressor that Iranians experienced in their new countries. Underemployment was reported to lead to insecure economic conditions, high stress levels, depression, anxiety, and other mental disorders [14, 28–30]. Underemployment and unemployment contribute to low self-esteem and self-confidence in Iranian immigrants, who were previously proud of their

prominent employment roles in their home country [24]. Lipson [28] highlighted that even highly skilled Iranian professionals could not find a suitable work upon arrival to the USA. The value of employment was exemplified by Iranian women in Canada, who conveyed that a meaningful occupation can mitigate painful experiences of immigration, such as separation from their children [14, 31].

Lack of information about health care services

Limited knowledge of health care services is another obstacle that Iranian immigrants often faced upon arrival to their host countries. Lack of awareness of health care services can delay and inhibit health care-seeking activities, and is likely exacerbate existing conditions [32]. In some countries such as Canada, immigrants are provided with many forms and pamphlets about daily living needs including information about available health services. In some cases, these resources have been described by Iranian immigrants as being too long and difficult to understand [32].

Access to health care services is critical in addressing mental health problems of immigrants. Results of a study showed that approximately 28 % of Iranian immigrants living in Germany were suffering from untreated mental disorders because their lack of access to appropriate mental health services [22]. Likewise, Neale et al. [33] identified that confusion and lack of information about the Australian health care system resulted in increased mental problems for immigrants.

Lack of social support

Leaving friends and families behind during the immigration process is a painful, yet common experience. Lack of social support can negatively affect individuals' health [28]. While, support from family and friends and a social network may mitigate the adverse impacts of immigration-related stressors, such as unemployment and poor language proficiency [25]. Lipson [28] described Iranians as a multi-cultural, multi-language, and a multi-religion population, and therefore, they were not frequently part of a cohesive homogenous social network. In contrast, a study in Sweden found that 72 % of Iranians had a social network; however, the remaining subset (28 %) reported poor social networks and social support and associated mental health problems [30].

Sense of discrimination

Iranian immigrants reported experiencing discrimination. Ten of the 26 studies considered discrimination to be a significant factor leading to depression and mental disorders [24, 28–31, 34–37]. In a study, 59.6 % of Iranian immigrants living in Sweden had perceived ethnic discrimination [30]. Similarly, Wiking et al.'s study [36] in Sweden found that 34 and 51 % of Iranian men and women, respectively, experienced discrimination when using health care services. However, Martin [37] did not report any forms of discrimination against this ethnic minority by health care providers and physicians in the USA. Yet, discrimination in educational centres, such as schools and English language courses has been reported by Iranian immigrants in studies that were carried out in the USA and Canada [29, 31]. Some immigrants felt they were judged negatively on because of their religion and accent [29].

Cultural issues

Culture shock

Culture shock is defined as diversities in expectations, values, and social norms that might be experienced by immigrants in western countries either in their social communications although they may not react effectively to this problem [28, 34, 35]. Divergent cultural norms can result in conflict between parents and children, child-rearing styles, relationship breakdown, and divorce [14, 28]. Inability to adjust to cultural differences can contribute to depression in Iranians [36]. Cultural differences can also influence immigrants' health seeking behaviours. Some immigrants experience numerous communication problems, not only because of their English language deficiencies, but as a result of cultural misunderstandings wherein health providers misinterpret, immigrants' discomfort or distress [28]. Another cultural difference between western countries and Iran relates to sexual content in the media and community. Many Iranian women in these countries are concerned about the effects of these exposures on their relationship with their husband and resultant expectations [37].

Intimate partner violence

Violence by intimate partner was reported in three of the 26 articles [24, 26, 38]. Violent behaviours may include being kicked, slapped, dragged, shoved, forced to have sexual intercourse, beaten, and restricted from attending social activities [38]. An Iranian woman in Sweden reported that her husband did not allow her to go to work or attend classes. Consequently, she divorced him to maintain her dignity and mental wellbeing [24]. Although several studies found that exposure to family violence was strongly associated with self-reported mental health problems of Iranian immigrants [24, 26], Guruge et al.'s study [38] failed to find a significant relationship between health status and exposure to violent behaviours among this immigrant population.

Discussion

In this review, we have highlighted the challenges that Iranian immigrants encounter during resettlement in host countries, and discussed the impact of associated

negative experiences on their health and wellbeing. The results of this review revealed that immigration may contribute to adverse psychological outcomes. These data contributed to development of a conceptual framework that addresses the main challenges faced by Iranian immigrants across pre-during-post migration phases and how these experiences affect the immigrants' mental health, including experience of stress, anxiety, and depression (Fig. 2).

The conceptual framework reflects social and cultural issues contributing to mental health problems among this immigrant population group. Social issues, including experience of discrimination, language barriers, lack of information about health care services, lack of social support, and unemployment can have adverse effects on immigrants' health. Similarly, cultural issues including intimate partner violence and culture shock increase their risk of developing physiological problems. These key factors are discussed in relation to the health of immigrants.

The challenges identified in the literature appear relevant to many immigrant populations, however, Iranian immigrants are likely to be particularly at higher for mental disorders. Pre migration experiences, such as the Islamic revolution of Iran, the eight-year Iran-Iraq War, and the recent economic sanctions against this country can negatively affect Iranians' mental health.

The findings of this review also suggest that language barriers hinder effective communication of immigrants with mainstream communities, leading to social isolation, and lack of utilisation of social services, including health care services [3, 14, 27–29, 31, 33, 40, 43]. These negative experiences have been linked to exacerbation of mental health problems in this population group [44]. Yet, health care workers do not perceive linguistic limitations as a barrier to the use of health care services and poor health status of immigrants [32]. From the point of view of health providers, cultural misunderstanding and lack of awareness of health care services are more important factors that can result in dissatisfaction with health care systems rather than language insufficiency [32]. Another migration-related factor which influences the health of immigrants is their employment status. Almost all studies in this review asserted that unemployment and underemployment were common challenges that Iranian immigrants endured [14, 24, 28–31]. These studies depicted the negative effects of unemployment on mental health of immigrants, such as reduced self-esteem and self-confidence and high levels of stress, anxiety, and depression. Unemployment is particularly problematic for Iranian immigrant compared to other Middle Eastern immigrants, as they are more likely to be highly educated and possess high social standing in their origin country. The inverse relationship between education and employment has contributed to poor mental health outcomes among Iranian immigrants [26, 45].

Generally, immigrants report lack of social support in a new country. While Iranians have been observed as a well-organised community in Sweden [30], another study reported that Iranians do not develop a cohesive organised community in the USA [28]. This was partially related to the existing diversities in Iranian's culture, religions and political and economic issues, which are often carried forward into immigrants' new life [46]. The inconsistency in the findings may be a result of different methodologies employed, timing, and settings of the studies. Further, the political climate that characterises different time periods possibly contributed to the immigrants' socialisation and their congregation behaviours. For example, the Islamic revolution of Iran, and the resultant political unrest may have influenced Iranians' behaviours at that time, resulting in limited trust and unitedness among Iranian immigrants. After several decades of political conflict, however, Iranians may have decided to become more united to be able to help themselves and fellow immigrants in a new country. Evidence reveals a direct relationship between lack of social support and mental disorders [28, 30], yet, social support cannot guarantee mental wellbeing [47].

Many studies have reported the experience of different types of discriminations by Iranian immigrants, and how these negative social experiences affected different aspects of the immigrants' life, particularly their mental health [24, 30, 31, 39]. It is argued that discrimination towards immigrants is likely to be underestimated due to language and cultural differences [48]. The media's negative portrayal of Islam and Iran is likely has contributed to the public's perceptions about migrants from Middle East and their discriminative behaviours. Discrimination can lead to mental health disorders, reduced self-confidence, and social isolation, making acculturation and resettlement more difficult for immigrants [40].

Apart from the social challenges, exposure to a new culture and new ways of living can be the source of considerable dissonance among family members, affecting their relationships and expectations of each other. Iranian immigrants have been recognised as people who are willing to integrate with host cultures, but they also do not like to give up their customs [45]. In other words, Iranians carry their 'cultural baggage' as well as demographic profiles wherever they go [14, 36]. Intimate partner violence is likely to be intensified by migration processes and the related stresses, increasing the risk of developing mental health problems such as anxiety and depression among immigrants [24, 26]. Guruge et al. [38], however, did not find a significant relationship between intimate partner violence and mental disorders [42]. This study failed to provide an explanation for the inconsistent finding. The

small sample sizes of the relevant studies may account for the inconsistency in the findings. Studies with larger sample sizes would be necessary to help generalise the results to the wider community. Overall, the findings of this review suggest that Iranian immigrants are at higher risk of developing mental health problems. While mental health is viewed as part of overall health in Iranians' culture and medicine [39], the considerable cultural stigma towards mental illnesses may hinder the use of mental health services for Iranian immigrants and can hinder seek of mental health services [14].

The literature on immigrant has mainly focused on negative outcomes of immigration, and overall immigrants have been portrayed in the literature as 'victims' in immigration process, however, Sulaiman-Hills and Thompson (2012) in their study on Kurdish and Afghan refugees in Western Australia and New Zealand established a new perspective on immigration. They found that migration could provide new education and occupational opportunities for immigrant women [49]. In line with this finding, evidence suggests that gender plays a role in mental health of immigrants [26, 36]. How the role of gender in resettlement process and mental wellbeing of Iranian immigrants is still controversial. While some studies suggest that Iranian men have a higher level of acculturation and superior mental health compared to Iranian women [41, 50, 51], Moghissi (1999) found that compared to men, Iranian women were healthier mentally and could better integrate into Canada's society. This finding was justified by the fact that Iranian women are used to accepting changes and adjusting to changes due to sociocultural factors. For example, many Iranian women have to live with their husband's family despite their divergent attitudes and culture. Though these experiences Iranian woman learn strategies to cope with new changes [41].

Overall, there is a shortage of studies focusing on Iranian immigrants and their mental health issues, likely due to the difficulties in conducting research on minorities. Possible positive outcomes of immigration, such as freedom, living in a 'well-organized' society, greater facilities, and support of government, need to be explored by research, particularly from immigrant women's perspectives [49].

Conclusion

The conceptual framework derived from this integrative review suggest that mental health of Iran immigrants can be affected by the challenges that their encounter across pre, during, and post phases of migration. Pre migration stresses, language barriers, unemployment, lack of information about health services, social isolation, experience of discrimination, cultural shock as well as intimate partner violence can adversely affect wellbeing and mental health of Iranian immigrants. These factors should be considered by policy makers and health care professionals when developing polices or interventions to improve the health of immigrants.

Competing interests

The author(s) declare that they have no competing interests.

Authors' contributions

All authors participated in the design of the study. PMD, LG and MD provided critical feedback on drafts. All authors read and approved the final manuscript.

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Appendix 7: Approval from the multicultural community centre

Granville Multicultural Community Centre Inc

8 Factory Street, Granville NSW 2142
ABN 18 740 588 419

25 July 2014

Professor Davidson
Centre for Cardiovascular and Chronic Care
Faculty of Health, University of Technology, Sydney
Level 7, 235 Jones St
Ultimo NSW 2007

Dear Professor Davidson,

Granville Multicultural Community Centre (GMCC) is a non-profit organisation which offers a variety of services, educational and social activities to residents in the local area. The different programs provided are targeted to local needs. People from all backgrounds are eligible to receive assistance from this organisation. The Caravan of Love is supported by GMCC and is founded and coordinated by Djamileh Vambakhsh. Djamileh is a volunteer and GMCC supports the group as an unfunded volunteer group.

We understand that a PhD student for whom you are principal supervisor, Mrs. Sara Shisheghar, is undertaking a study entitled "Health and Socio-cultural needs of Iranian Asylum Seeker and Refugee Women Living in Metropolitan Sydney, Australia." Following discussions with Sara, we understand that the purpose of this study is to learn more about how Iranian refugee women transition to Australian life and their experiences with the Australian culture. Mrs. Shisheghar will also explore health needs, beliefs, and attitudes of the women.

We agree, in principle, to support this study by inviting Mrs. Shisheghar to attend weekly Caravan of Love activities from (July 2014) at the Granville Community Youth and Recreation Centre, in an effort to let our attendees know about the study and recruit any interested volunteer participants. If desired, Sara may be able to negotiate with the centre for the use of a private office to conduct interviews.

We understand that we can contact Sara Shishehgar or her supervision team if we have any concerns about the research. Furthermore, we have agreed with Sara that she will provide us with a project report upon completion of the study.

We look forward to working with Sara.
Yours sincerely

Paula Chegwidden
Manager
Granville Multicultural Community Centre

| P 9637 7600 | F 9637 9446 | E info@gmcc.org.au | W www.gmcc.org.au

Appendix 8: Invitation letter (Farsi)

UTS
UNIVERSITY OF TECHNOLOGY, SYDNEY

دعوتنامه

نیازهای سلامتی و فرهنگی-اجتماعی زنان پناهجوی ایرانی مقیم سیدنی، استرالیا

اینجانب سارا شیشه گر دانشجوی دانشگاه UTS می باشم. من در حال انجام یک مطالعه در رابطه با زنان پناهجو و پناهنده ایرانی مقیم سیدنی بوده و از همکاری شما کمال تشکر را دارم.
این مطالعه شامل یک مصاحبه رو در رو خواهد بود که هر مصاحبه حدود یک ساعت به طول خواهد انجامید. من از شما تقاضای شرکت در این مطالعه را به عنوان یک خانم ایرانی فارسی زبان که 2-3 سال است وارد استرالیا شده اید دارم. شما می توانید تجربیات خود را در رابطه با زندگی در یک جامعه جدید و همچنین عقاید و نگرش خود را در رابطه با زندگی در استرالیا و تاثیق آن بر وضعیت سلامت خود را با پژوهشگر در میان بگذارید.
قابل ذکر است که شما وادار به شرکت در این مطالعه نیستید. ولی در صورت تمایل به شرکت در این مطالعه لطفا به آدرس زیر با من تماس حاصل نمایید.

سارا شیشه گر، دانشجوی دکترا
دانشگاه UTS، طبقه هفتم، دانشکده Health ، Jones street 253-235 ، Ultimo، NSW 2007
تلفن: [redacted]
ایمیل: [redacted]@student.uts.edu.au

با احترام و سپاس فراوان

توجه:
این مطالعه توسط کمیته اخلاق تحقیقات انسانی تایید شده است. در صورت هرگونه شکایت یا تردید غیر قابل حل با پژوهشگر در رابطه با این مطالعه شما می توانید با کمیته اخلاق به آدرس زیر تماس حاصل نمایید. هرگونه شکایت مورد بررسی دقیق قرار خواهد گرفت و شما از نتیجه آن مطلع خواهید شد.
تلفن: 0295149772
ایمیل: Research.Ethics@uts.edu.au

Appendix 9: Invitation letter (English)

UTS
UNIVERSITY OF TECHNOLOGY, SYDNEY

INVITATION LETTER

Health and Socio-cultural Needs of Iranian Asylum Seeker Women Living in Sydney, Australia

Dear .....

My name is Sara Shishehgar and I am a PhD student at the University of Technology, Sydney.

I am studying Iranian asylum seeker women and would welcome your participation. The research will involve one face-to-face interview and should take no more than about 1 hour of your time. I have asked you to participate because you as an Iranian woman who has lived in Australia less than 3 years I am interested in hearing about your experiences, beliefs, and attitudes in relation to living in Australia.

Please understand that you do not have to participate in this research. But, if you are interested in participating, I would be glad if you would contact me at the phone number or email address below:

Sara Shishehgar PhD Candidate

University of Technology, Sydney

Faculty of Health

235-253 Jones Street, Ultimo, NSW 2007

Phone:
Email: @student.uts.edu.au

Yours sincerely,

NOTE:

This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au), and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Appendix 10: Participant information sheet (Farsi)

UTS
UNIVERSITY OF TECHNOLOGY, SYDNEY

فرم اطلاعات
نیازهای سلامتی و فرهنگی-اجتماعی زنان پناهجوی ایرانی مقیم سیدنی، استرالیا

چه کسی مسئول انجام مطالعه می باشد؟

اینجانب سارا شیشه گر دانشجوی دانشگاه UTS می باشم و این مطالعه تحت نظارت پروفسور Davidson، دکتر DiGiacomo و دکتر قلیزاده صورت خواهد گرفت.

هدف از این مطالعه چیست؟

هدف از این مطالعه دانستن نحوه انطباق زنان پناهجوی ایرانی با زندگی و فرهنگ استرالیایی و رابطه آن با وضعیت سلامتی و نیازهای سلامتی و بهداشتی این گروه می باشد.

در صورت پذیرش برای شرکت در این مطالعه چه مواردی شامل حال شما خواهد شد؟

در صورت تمایل به شرکت در این مطالعه، پژوهشگر یک مصاحبه رو در رو به مدت حدود یک ساعت با شما انجام خواهد داد. در طول مصاحبه، پژوهشگر از شما در باره تجربیات زندگی در سیدنی و عقیده و نگرش شما راجع به فرهنگ استرالیایی خواهد پرسید. همچنین از شما درخواست خواهد شد که درباره تجربیات فرهنگی، اجتماعی و سیاسی خود قبل و بعد از مهاجرت که احتمالا روی سلامتی شما تاثیر گذاشته اند توضیحاتی بدهید.

مصاحبه به زبان فارسی صورت خواهد گرفت و ضبط خواهد شد. در طول مصاحبه در صورت نیاز پژوهشگر نوت برداری خواهد کرد. هیچگونه نام و مشخصات فردی در هیچ جا ثبت و ضبط نخواهد شد. تمامی اطلاعات و تجربیات شما محرمانه خواهند ماند. تمامی صداهای ضبط شده در یک کمد قفل شده جدای از فرمهای رضایت نامه نگهداری خواهد شد. فقط پژوهشگر و همکاران تحقیق وی (نامشان در بالا ذکر شد) به اطلاعات شما دسترسی خواهند داشت.

در گزارش نهایی، پژوهشگر از کلمات بیان شده توسط شما بدون عنوان نام شما استفاده خواهد نمود. نام شما در هیچ مقاله یا کنفرانس و سمیناری اعلام نخواهد شد. در مطالعات بعدی، در صورت نیاز به اطلاعات شما، پژوهشگر موظف به کسب اجازه مجدد از کمیته اخلاق می باشد.

شرکت در این مطالعه داوطلبانه می باشد و هر زمان که تمایل داشته باشید می توانید از ادامه شرکت در آن انصراف دهید.

آیا شرکت در این مطالعه هیچگونه سود و یا زیانی در پی دارد؟

هیچگونه سود و زیان مستقیمی برای شرکت در این مطالعه در نظر گرفته نشده است. هرچند، پژوهشگر امیدوار می باشد که نتایج این مطلعه کمکی باشد جهت بهبود شرایط زندگی پناهجویان و پناهندگان ایرانی مقیم استرالیا.

در صورت تمایل شما می توانید از نتایج نهایی این مطالعه مطلع شوید.

چرا شما دعوت به شرکت در این مطالعه شدید؟

تجربیات زندگی، عقاید و نگرش شما راجع به روش زندگی در استرالیا به عنوان یک خانم پناهجو/پناهنده ایرانی فارسی زبان که سن بالاتر از 18 و کمتر از 40 سال دارید و 2-3 سال پیش وارد استرالیا شده اید، می تواند ما را در جهت بررسی وضعیت سلامتی و نیازهای فرهنگی- اجتماعی این جمعیت در حال افزایش در استرالیا یاری نماید.

آیا شما وادار به شرکت در این مطالعه می باشید؟

شما به هیچ عنوان مجبور به شرکت در این مطالعه نمی باشید.

در صورت عدم تمایل به شرکت در این مطالعه چه پیش خواهد آمد؟

عدم تمایل به شرکت در این مطالعه هیچ عواقبی در پیش نخواهد داشت و پژوهشگر مجددا با شما تماس نخواهد گرفت.
در صورت تمایل به انصراف از ادامه مطالعه، شما قادر خواهید بود در هر زمان بدون نیاز به هیچ توجیهی مطالعه را ترک کنید.

در صورت هرگونه نگرانی در رابطه با این مطالعه می توانید با پژوهشگر ویا همکاران او تماس حاصل فرمایید.

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در صورت تمایل به صحبت با شخصی که در ارتباط با این مطالعه نیست شما می توانید با اداره اخلاق پژوهش با شماره تلفن 0295149772 تماس حاصل نموده و کد ---------- را وارد نمایید.

Appendix 11: Participant information sheet (English)

UTS
UNIVERSITY OF TECHNOLOGY, SYDNEY

INFORMATION SHEET

Health and Socio-cultural Needs of Iranian Asylum Seeker Women Living in Sydney, Australia

My name is Sara Shishehgar and I am a PhD student at the University of Technology, Sydney.
My supervisors are Professor Patricia Davidson, Dr Leila Gholizadeh and Dr Michelle DiGiacomo.

WHAT IS THIS RESEARCH ABOUT?

This research is to find out about more about how Iranian asylum-seeker women transit to Australian life and how they found the Australian culture. It also aims to explore their health need and its relation with their lived experience, beliefs and attitudes toward Australian culture.

IF I SAY YES, WHAT WILL IT INVOLVE?

If you choose to participate in this study, the researcher will meet with you for approximately 1 hour. During this time, the researcher will ask you to describe your experiences of living in Sydney and your attitudes and beliefs about Australian culture. Also you will be asked about your pre and post migration social, political and cultural experiences which may influence your health condition. The interview will be in Persian (Farsi) and will be tape-recorded and note taken. No names or other identifying information will be recorded. All of your information and experiences will be confidential. All tapes will be kept in a locked cabinet and be separate from your consent forms.

Only the researcher and her thesis committee members will access to your information. In final reports, the researcher might use your actual words but will never use your name. Your name will not appear in any publication or presentation. In future studies, if the researcher needs to use this information again, she will submit a request to the appropriate ethics review committee.

You do not have to be in this study if you do not wish to be. You can withdraw from the study at any time.

ARE THERE ANY RISKS/INCONVENIENCE?

There will be no harm or direct benefit to you by participating in this study. However, the researcher hopes that the information obtained will be used to facilitate Iranian asylum seekers and refugees to transit and settle in Australia in the best way. You are welcome to know about the results of this study if you wish.

WHY HAVE I BEEN ASKED?

Your lived experiences, beliefs and attitudes toward Australian life as an Iranian woman who are between 18 and 40 year old, speaking Farsi and live in Australia for 2 to 3 years might assist the

researcher to explore the health and socio-cultural needs of this growing population in Australia during the resettlement period.

DO I HAVE TO SAY YES?

You don't have to say yes.

WHAT WILL HAPPEN IF I SAY NO?

Nothing. I will thank you for your time so far and won't contact you about this research again.

IF I SAY YES, CAN I CHANGE MY MIND LATER?

You can change your mind at any time and you don't have to say why. I will thank you for your time so far and won't contact you about this research again.

WHAT I SHOULD DO IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think I or my supervisor can help you with, please feel free to contact me (us) on information provided as follow:

Sara Shishehgar Ph.D Candidature

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If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer on 02 9514 9772, and quote this number *(give UTS HREC Approval Number)*

Appendix 12: Interview guide

Health and socio-cultural needs of asylum seeker women living in Sydney, Australia

Semi-structured interview guide (English)

Pre-migration experiences

Tell me about your life story in Iran.

If any health issue emerged: how it affected your life and decision to leave Iran?

What pushed you to leave Iran?

Transit experiences

Tell me about story of you journey in Indonesia.

Tell me your story of travel on the boat.

If any distressful experiences: How did you manage the stressful condition (if you did)?

Post-migration experiences

In detention

Tell me your experiences of living in detention centre.

How did you perceive your health status in detention?

If any distressful experiences: How did you manage the stressful condition (if you did)?

In the community

Tell me your story of life over 2-3 years of living in Sydney.

How do you perceive your living status within the host community?

If any distressful experiences: How do you manage the stressful condition (if you do)?

How do you explain your health status?

If any health concern: how do you expect to be treated?

If any concern about health care services: any comment or recommendation for providing better health care?

Aspiration for future

How do you see your future in Australia?

What are your expectation of your future life in Australia?

Do you have any comments or suggestions to help you in achieving your aspiration/better future?

Any comment or further concern do you have?

Appendix 13: Socio-demographic questionnaire

Health and Socio-cultural Needs of Iranian Asylum Seeker Women Living in Metropolitan Sydney, Australia

Socio-Demographics Questionnaire

Please answer each of the questions below about you. It should take about 5 minutes to complete. This information will be kept strictly confidential.

Age	
Marital Status	Single (never married)
	Married
	Separated
	Divorced
	De facto
	Widowed
Number of Children	0
	1
	2
	More than 2
Educational Status	No schooling
	Primary school
	High school
	Tertiary
Employment Status in Iran	Part-time
	Full-time
	Casual
	Volunteer
	No working
Financial Status in Iran	Low
	Good
	Excellent
Employment Status in Australia	Part-time
	Full-time
	Casual
	Volunteer
	No working
Date of Entry to Australia	
Name of the Detention	
Length of Stay in Detention	
Religion	Muslim
	Christian
	Jewish
	Bahaee
	Others

Appendix 14: Ethics approval letter from UTS Human Research Ethics Committee

UTS
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11 November 2014

Sara Shishehgar
Centre for Cardiovascular and Chronic Care
Faculty of Health
Level 7, 235 Jones St
ULTIMO NSW 2007

Dear Sara,

UTS HREC 2014000363 – Prof Patricia Mary DAVIDSON, Dr Michelle DIGIACOMO, Dr Leila GHOLIZADEH (for Ms Sara SHISHEHGAR, PhD student) – "Health and Sociocultural Needs of Iranian Asylum Seeker and Refugee Women Living in Metropolitan Sydney, Australia"

Thank you for your response to the Committee's comments for your project titled, "Health and Socio-cultural Needs of Iranian Asylum Seeker and Refugee Women Living in Metropolitan Sydney, Australia". Your response satisfactorily addresses the concerns and questions raised by the Committee who agreed that the application now meets the requirements of the NHMRC National Statement on Ethical Conduct in Human Research (2007). I am pleased to inform you that ethics approval is now granted. The Committee are in the process of developing a set of guidelines for research which directly or incidentally discloses illegal activity or criminal victimisation. We will send you these guidelines to support your research once finalised.

Your approval number is UTS HREC REF NO. 2014000363 Your approval is valid five years from the date of this letter.

Please note that the ethical conduct of research is an on-going process. The *National Statement on Ethical Conduct in Research Involving Humans* requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

If you have any queries about your ethics clearance, or require any amendments to your research in the future, please do not hesitate to contact the Ethics Secretariat at the Research and Innovation Office, on 02 9514 9772.

Yours sincerely,

M R Haas

Professor Marion Haas
Chairperson
UTS Human Research Ethics Committee

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