

**The Impact of Immigration on the Health and Wellbeing  
of Iranian Immigrant Women: Voices from  
Ottawa/Gatineau**

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# **Abstract**

This thesis focuses on the experiences of twelve migrant women from Iran residing in the Ottawa/Gatineau area to examine the impact of immigration on their health and wellbeing. The study also aims to explore an understanding of health/wellbeing as situated in, and contextualized by, women's lived experiences, as well as to investigate the determinants that impact on participants' wellbeing. Semi-structured and in-depth interviews were conducted and an intersectional approach with an anti-oppression lens was employed. The results reveal that the majority of women were in good health before migration, which supports the healthy immigrant effect. One significant finding was that eight women reported that their health/wellbeing had remained stable or even improved after immigration. However, four participants experienced health deterioration that resulted in permanent disability for one of them. The results illustrate that the health/wellbeing of respondents was shaped by a complex web of intertwined determinants beyond individual health behaviours.

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# Chapter One: Introduction

Immigration is a significant component of globalization and remains an important force shaping Canadian identity (Gushulak, Pottie, Roberts, Torres, & DesMeules, 2011). Immigrants were responsible for two-thirds of Canadian population growth in the intercensal period of 2001 and 2006 (Chui, Tran, & Maheux, 2007) and by 2011, more than 20% of Canada's population were foreign-born (Chagnon, 2013; Statistics Canada, 2013). In 2012, 257,887 immigrants entered Canada, more than half of them were women (Citizenship and Immigration Canada (CIC), 2012b). Asia—including the Middle East—was Canada's largest source of newcomers (Statistics Canada, 2013). Indeed, immigration is a significant component of Canada's population growth, and ensuring the health and wellbeing of immigrants is an important national priority (Hyman, 2011).

Many studies have suggested that, upon arrival, the health status of immigrants is better than the Canadian-born population; this phenomenon is known as the “healthy immigrant effect” (Chen, Wilkins, & Ng, 1996b; see also literature review). After settling, some immigrants lose this advantage over time (Ng, Wilkins, Gendron & Berthelot, 2005; Vissandjée, Desmeules, Cao, Abdoll & Kazanjian, 2004). Non-European immigrants are twice as likely to report worsening health status (Ng et al., 2005) and among them women, again those from non-European countries, are more vulnerable to this trend (Vissandjée et al., 2004; Wu & Schimmele, 2005a).

## **Objectives**

As an Iranian immigrant woman finding myself confronted by the problems of immigration, which have sometimes overwhelmed me, I have wondered whether immigration affects my health/wellbeing. Does immigration impact the wellbeing of other Iranian immigrant women? These questions have encouraged me to design my study in a way to find my answers.

This study aims to understand the impact of immigration on the health/wellbeing of Iranian immigrant women in Ottawa/Gatineau. Moreover, it is designed to gain an understanding of health/wellbeing as situated in, and contextualized by, their lived experiences. Furthermore, this research tries to find what Iranian immigrant women see as determinants of their health, and also aims to explore their health concerns and needs. Finally, the study intends to highlight areas that may be in need of assessment in order to improve the health/wellbeing of Iranian immigrant women in Ottawa/Gatineau.

Before moving to the health/wellbeing of immigrant women, I begin by providing a brief examination of the historical development of key institutional features of immigration policy in Canada; I then offer an overview of the history of Iranian immigration in general and their settlement in Canada in particular.

## **History of Canada's Immigration Policy**

Immigration policy in Canada can be described by the acts, regulations, guidelines and practices which define who is allowed to come to Canada and, ultimately, who might be granted citizenship (Abu-Laban, 1998; Green & Green, 2004). The policy is a complex entity

that has two goals: short term (current labour market); and long term (economic and demographic growth) (Green & Green, 2004). Immigration policy for the greater part of Canadian history has been explicitly racist and sexist (Arat-Koc, 1999; Gupta, 1999) and has been accompanied by a history of exclusion (Agnew, 2009b).

During the last decades of the nineteenth century, Canada opened its door to immigration in order to promote the settlement of Western Canada (Côté, Kerisit, & Côté, 2001). Therefore, the country was faced with large immigration inflows from the U.S. and overseas, which forced the government to introduce a new Act in 1910 (Green & Green, 2004). The Act was amended in 1919 (Côté et al., 2001) and expanded the power of the government over the level of ethnic composition of immigrants when admission was based solely on country of origin. The Act divided the world into “preferred countries” and “non-preferred countries” (Green & Green, 2004, p. 108). While immigrants from Britain, the United States, and most Northern and Western European countries were treated as “preferred”, immigrants from Eastern and Southern Europe were considered as “non-preferred” and faced stricter regulations. Finally in 1956, immigrants from all regions of Europe became eligible; if they met the needs of the labour market (Green & Green, 2004).

For non-white and non-European persons “whose race was considered unsuitable to the Canadian climate” (Côté et al., 2001, p. 19), immigration policy was more restrictive and the Act of 1910 prohibited the settlement of immigrants from Asian origin and severely curtailed entry of African-Americans. However, Chinese were brought in from China to help build the railway in 1850s but after the completion of their dangerous work on the railway in 1885, the state imposed an immigration tax on the Chinese and, later, in 1923, prohibited the immigration of Chinese citizens to Canada by passing the Chinese Immigration Act that

excluded all but a very few exceptions (Coté et al., 2001). According to Troper, an immigration historian, there are other explicit examples of past discrimination in Canada's immigration policy in the early twentieth century: the exclusion of black Oklahoman farmers from entering to Canada, the refusal of more than 350 South Asians to leave a ship—the Komagata Maru—after landing in Vancouver, and the exclusion of European Jews fleeing fascists prior to the outbreak of the Second World War (as cited in Black, 2013, para. 9).

As a result, limited numbers of men from India, China, and Japan gained entry in the early part of twentieth century; however, their wives were mostly kept out (Agnew, 2009b). Historically, gender inequality has also been apparent through the history of immigration policy. Indeed, women were subject to sexist legislative provisions and admitted as wives and dependents. While some women of European countries benefited from the provisions governing family reunification and entered Canada, it did not extend to women of colour who would have to wait until the second half of the twentieth century to be granted entry to Canada (Coté et al., 2001).

In 1967, the point system as a new “non-discriminatory” (Arat-Koc, 1999, p. 207) immigration policy based on an objective scale was introduced. However, the point system allowed the government to “discard the most blatant expressions of gender, race, and class bias, but other racist assumptions that were invisible (or thought to be normal and natural) remained” (Agnew, 2009b, p. 15). The point system was to aid in the “evaluation of applicants’ potential contribution to and value for Canada solely on the basis of their occupational skills and their expected place in the labour market” (Arat-Koc, 1999, p. 209; see also Abu-Laban, 1998; Green & Green, 2004). As the history of Canada's immigration policy vividly illustrates, market considerations have often trumped other objectives.

Therefore, the concept of selection from the country of origin of the prospective immigrant was shifted to the individuals' place in an immediate labour market which "reflects the fact that immigration was and is an economic policy tool in Canada" (Green & Green, 2004, p. 120). In other words, the requirements of point system have not been "value-free" and they "reflect prevailing Canadian political and economic power structure[s]" (Abu Laban, 1998, p. 76). Neoliberalism, which promotes market economy, shapes Canadian policies and practices (Mitchell, 2001) and with the spreading of neo-liberalism, the enhancement of market forces has become the overarching goal of immigration policy.

I pause at this point to mention that the history of Canadian immigration policy which is based on ostensibly objective criteria, has not only been racist and gendered (Arat-Koc, 1999; Gupta, 1999), but it has also been disableist and homophobic. People with disabilities were also prohibited from entering Canada and certain diagnoses and labels such as epilepsy were determinative of admissibility regardless of the cost of the treatment (Mossoff, 1998-1999). The Immigration Act also blocked the admission of LGB people to Canada until 1977, and it has been only less than two decades that Canadians have been allowed to sponsor the landing of same-sex partners (O'Neill & Sproule, 2011). However, there is still room for discrimination and the government requires certain language skills, rejects some occupations (Black, 2013), and makes certain types of disabilities inadmissible (Iyioha, 2007-2008; Mosoff, 1998-1999). Moreover, same-sex marriage only exists in a few countries and cohabitation due to persecution or penal code can be dangerous or may not be financially viable (LaViolette, 2004; Ontario Women's Justice Network, 2009).

The point system has been amended several times; however, the regulatory system of 1967 has shaped the framework of immigration policy until the present (Green & Green,

2004). In 1976, the Immigration Act was passed. The objectives of this Act “are family reunification, non-discrimination, humanitarian concern for refugees and the promotion of Canada’s social, economic, demographic and cultural goals” (Coté et al., 2001, p. 23); in 2002, the Immigration and Refugee Protection Act (IRPA) replaced the Immigration Act of 1976. Since then, Canada’s immigration program has been based on IRPA and its regulations (CIC, 2012b).

As the result of changes in Canadian’s immigration policy, as well as international events affecting the movement of people (Chui et al., 2007, Gushulak et al., 2011), an earlier predominance of immigration from Europe has shifted to a significant number of immigrants from Asia. For instance, in 1971, near 60% of immigrants who entered Canada were from Europe (Chui et al., 2007) while in 2011, they accounted 14% of newcomers—including the United Kingdom (CIC, 2012b). On the other hand, the proportion of Asian-born newcomers—including the Middle East—increased from 12% in the late 1960s (Chui et al., 2007) to near 57% in 2011 (Statistics Canada, 2013).

The IRPA establishes the criteria and guidelines to be met by people seeking entry into Canada. According to the IRPA, three main categories of permanent residents are defined: (1) family class which includes spouses and conjugal or common-law partners, dependent children, and other eligible relatives (2) economic immigrants – skilled workers, provincial nominees, investors, entrepreneur, self-employed persons, Canadian experience class, and live-in caregivers and (3) refugees: convention refugee and persons in need of protection. There is another group of permanent residents, other, who may be granted permanent resident status but do not qualify in any of the main categories (CIC, 2012a).

## History of Iranian Immigration to Canada

To establish the context for my research question, I briefly introduce Iran and trace some of the ways in which social, economic, and political upheavals have framed Iranians immigration en masse in the last decades.

Iran is a cat-shaped country, “known as ‘The Land of Rose and the Nightingale’” (Milani, 2011, p. 193), home to one of the world’s oldest civilizations (Katouzian, 2013; Milani, 2011; Shoamanesh, 2009) and an oil-rich nation (Moaveni, 2009; Muys, 2009) that has been in existence for near three millennia (Katouzian, 2013). Iran, according to Sullivan, was not formally colonized; however, due to its rich oil resources, it was not free of Western intervention (as cited in Dossa, 2006, p. 349). This country is a land that Milani (2011), quoting from Behbahani—one of the most prominent figures of the contemporary Persian poets—has defined as:

blessed with millennia of written history and civilization; a land where Zoroaster once spread his message of good deeds, happiness, and light; a land where Cyrus once championed justice, freedom and humanity, where he inscribed in stone a foundation for the defense of human rights (p. 176).

Despite the old history of civilization, and with the exception of ancient sporadic immigration (Shoamanesh, 2009)—fleeing of Persians who followed the Zoroastrian faith to western India after the Arab conquest in AD 936, and followers of the Bahá’í faith in the mid-19th century (Hakimzadeh, 2006)—emigration is a relatively new phenomenon in Iran (Shoamanesh, 2009). Indeed, the recorded history of sending students abroad for education (Bozorgmehr, 1998; Bozorgmehr & Douglas, 2011; Keddie, 2003/2006; Naghdi, 2010) and migrant workers abroad is only about one hundred years old (Naghdi, 2010).

However, mass migration of Iranians has been the by-product of the Iranian Revolution of 1979 and its aftermath (Bozorgmehr, 1998; Katouzian, 2013; Naghdi, 2010; Parvizian, Khademolqorani, & Askari Tabatabaei, 2011; Shoamanesh, 2009). The combination of the Revolution and its economic, social, and political consequences like unsafe and unpleasant conditions, political instability, religious and ethnic persecution (Ebadi, 2006; Moghissi, Rahnema, & Goodman, 2009; Shahidian, 1999; Torbat, 2002), and the eight-year Iran-Iraq war—which began in 1980—and increasing economic problems, rampant inflation, currency devaluation, the growth of unemployment (Ebadi, 2006; Katouzian, 2013; Keddie, 2003/2006; Naghdi, 2010; Shahidian, 1999; Shoamanesh, 2009), fear of being sent to their deaths, and having to undergo military service (Ebadi, 2006; Moghissi et al., 2009; Shoamanesh, 2009) has forced a large portion of Iranians to flee to other countries—among them, Canada. Apart from the Iranian government’s flawed policies, the role of imposing sanctions against Iran which have taken a serious toll on the country’s economy and resulted in more disappointment among Iranians, cannot be ignored (Salehi-Isfahani, 2008).

Moreover, Iran has one of the youngest populations in the world (Hosseini-Chavoshi & Abbasi-Shavazi, 2012; International Organization for Migration, 2009; Milani, 2011; Parvizian et al., 2011) and Iranian culture puts immense emphasis on education (Shoamanesh, 2009); moreover, the shortage of seats in universities is well documented (Parvizian et al., 2011). As a result, some Iranians left Iran to pursue an education (Keddie, 2003/2006; Moghissi et al., 2009; Shoamanesh, 2009), some with the expectation of better futures for their children and better living standards for the family (Carrington & Detragiache, 1999; Moaveni, 2005, 2009; Moghissi et al., 2009) —and this trend has continued.

Furthermore, the 1979 Revolution in its early years, generally speaking, severely curtailed the rights to which women had become accustomed; the government imposed gender restrictions in some educational fields, changed the marriage and divorce laws, and ordered several social restrictions, including imposing the compulsory veiling regardless of a woman's citizenship or religion. These measures caused widespread disappointments among Iranians, providing yet another reason for the massive exodus of women and families who had daughters. Moreover, while the government has improved women's literacy, this has not translated into equal employment opportunities (Ebadi, 2006; Keddie, 2003/2006).

The mass Iranian migration consisted of various population strata and social classes. While the first wave of Iranian immigrants who left the country in the initial period immediately before and after the Revolution were mostly urban middle and upper classes (Shahidian, 1999) that included monarchists, highly educated people, and religious minorities (particularly Jews and Bahá'ís); in the second wave—lasting from the mid-1990s to the present—working-class immigrants in search of upward social mobility have been added to the group of highly skilled and educated immigrants and increased the heterogeneity of the Iranian exodus (Ebadi, 2006; Hakimzadeh, 2006; Shoamanesh, 2009). Additionally, common to these waves are refugees and asylum seekers (Shoamanesh, 2009). As the result of drastic transformation in Iranian society, Iranians have left the country in droves; whether by obtaining visas or getting out by any cost in hands of smugglers (Ebadi, 2006; Hakimzadeh, 2006).

To conclude, the Revolution of 1979 resulted in the largest emigration of Iranians who are extremely heterogeneous with respect to age, gender, ethnicity, mother tongue, religion, political affiliation, education, social status, legal status, timing, and motivation for departure

(Hakimzadeh, 2006; Parya Trillium Foundation, 2012), and, in effect, created what Dallafar terms “the first major diaspora of Iranians” (2010, p. 276).

In Canada, Iranians are relatively new but a fast-growing immigrant community (Garousi, 2005; Vahabi, 2011). Before 1961, only 130 Iranians had settled in Canada, but this number increased to nearly 25,000 in 1990 (Statistics Canada, 2007) and to more than 92,000 in 2006 (Statistics Canada, 2009; see Appendix 1). In other words, the introduction of the new Immigration Act in the 1960s facilitated the entry of the first Iranians to enter Canada (Shahidian, 1999); however, the Islamic Revolution in 1979 created a surge in immigration (Ahmed, 2008; Garousi, 2005; Moghaddam, Taylor & Lalonde, 1987; Shahidian, 1999). In the early post-revolutionary years, near half of Iranian migrants came to Canada as refugees (Dossa, 1999; Garousi, 2005). In addition to this majority group, since the 1990s a growing number of Iranians have migrated as entrepreneurs, investors (Hakimzadeh, 2006)—after the Canadian government added the investor class in 1986 (Green & Green, 2004)—skilled workers, and also students who then becoming landed immigrants (Garousi, 2005, see Appendix 2). According to the Organisation for Economic Co-operation and Development (OECD, 2012), in 2005-2006 Canada was the third main destination for Iranian immigrants among OECD countries whose profiles shows 61.4 % were highly educated and 47.3% were women. During the period 2001 to 2010, Iran became one of the top ten immigrant-sending countries to Canada (CIC, 2012b; Chagnon, 2013) and rose from eighth place in 2008 to fourth place in 2011 (Chagnon, 2013). In this year, the median age of immigrants from Iran was 32.6 and the proportion of men was slightly higher than women (Chagnon, 2013). Moreover, Iran has constantly been the most common place of birth of immigrants among Canadian permanent residents from Africa and Middle East

from 2001 to 2010 (CIC, 2012b). The history of Iranian settlement in Ottawa-Gatineau is similar to Canada. Before 1971, only a dozen Iranians had settled in this region, but this number increased to near 4,000 in 2001 (Statistics Canada, 2007, see Appendix 3).

## **Statement of Problem**

As previously mentioned, a growing body of literature suggests that the health advantage of some immigrants, particularly non-European women, disappears with increased length of time in Canada. It is also well documented that an individual's health is shaped by the resources and opportunities available to her or him and by how a society distributes its socio-economic resources, known as social determinants of health (Raphael, 2004). These determinants, as well as gender and other social markers impact the health and wellbeing of a populace (Spitzer, 2012). Indeed, immigrant women's health is influenced by their living conditions and environment, poverty, racialized status and marginalization, class inequalities, family and social support networks, and appropriate services and access to healthcare; as well as their ethnic, religious, sexual, and gendered identity (Khanlou, 2010; Hyman, 2001, 2011; Spitzer, 2011a).

Therefore, gender is one of the determinants of health (Spitzer, 2005) and cultural, socio-political and economic environments affect women's health and wellbeing at both individual and family levels (Oxman-Martinez, Abdool, & Loiselle-Leonard, 2000). Gender roles and ideologies, and inequities arising from them are inextricably linked with health (Bierman, Ahmad, & Mawani, 2009; Spitzer, 2009). Women have more responsibilities for taking care of the household and for raising children, which cause stress and strain (Mikkonen, & Raphael, 2010; Oxman-Martinez et al., 2000; Spitzer, 2005). However,

gender is not experienced as an isolated phenomenon; indeed, it is integrated and intertwined in myriad ways with other determinants of health.

Moreover, considering immigration experiences is important when examining immigrant women's health. The immigration process—the 'push-pull' factors that shape the decision to migrate, the journey itself, and settlement process—constitutes an experience of significant transition that includes new opportunities as well as potential hardships (Vissandjée, Thurston, Apale, & Nahar, 2007). In fact, a growing body of literature has suggested that immigration has to be considered as a determinant of immigrants' health (Hyman, 2004; Kinnon, 1999). Furthermore, the migration experiences of women fundamentally differ from that of men and they bear more deterioration of health than men (Vissandjée et al., 2004).

While the number of Iranian immigrant women in Canada has been rapidly growing, they are one of the least understood immigrant groups. Despite the fact that in the last few decades Canada has been host to tens of thousands of Iranian immigrants (Dossa, 1999; Sadeghi, 2008); due to a paucity of data on Iranian immigrants, it is difficult to draw any conclusions about the nature of the Iranian community in Canada (Dossa, 1999). Unfortunately with some notable exceptions (see Dossa, 1999, 2002, 2004 for Iranian immigrant women's mental health; Dastjerdi, 2007, 2012 for health care access of Iranian immigrants), research on Iranian women's health in Canada is limited; and to the best of my knowledge, no study to date has explored the health/wellbeing of Iranian immigrant women in the Ottawa/Gatineau area.

## **Research Question**

The central research question that this research aims to answer is:

Does immigration impact on the health/wellbeing of Iranian immigrant women who live in Ottawa/Gatineau?

The study also addresses the following sub-questions:

- What are Iranian immigrant women's understandings of health/wellbeing?
- How does immigration affect the health/wellbeing of Iranian immigrant women?
- What do Iranian immigrant women see as determinants of their health?
- What policies, programs, and services could best support Iranian immigrant women's health/wellbeing in the Ottawa/Gatineau region?

## **Purposes**

This research is significant for the following reasons: first, it contributes to existing literature by examining the impact of immigration on the wellbeing of Iranian immigrant women; second, the health and wellbeing of immigrants greatly influence the health of Canada as a whole; and third, Ottawa as the capital of Canada has been host to many Iranians but there is an apparent lack of studies about them in this city. Furthermore, enhancing the voices and visibility of immigrant women allows them to be empowered, which is the key component of a feminist health approach (MacDonnell, Dastjerdi, Bokore, & Khanlou, 2012).

## **Chapter Two: Literature Review**

From the literature accessed, it is evident that many studies related to the health of immigrant women in Canada have been carried out, but there are few studies that have examined Iranian Canadian women's health. This literature review provides some background on the key issues such as the healthy immigrant effect, the social determinants of health, immigrants' health, and Iranian immigrants' health. However, the literature review here is by no means exhaustive.

### **Healthy Immigrant Effect**

As mentioned earlier, a growing body of literature with respect to selected mental and physical indicators suggests that the health status of immigrants at the time of arrival is better than the Canadian-born population (Ali, 2002; Chen, Ng, & Wilkins, 1996a; Chen et al., 1996b; Deri, 2004; Gee, Kobayashi, & Prus, 2004; Hyman, 2001, 2004; McDonald & Kennedy, 2004; Newbold, 2009; Newbold & Danforth 2003; Ng et al., 2005; Perez, 2002; Vissandjée et al., 2004; Wu & Schimmele, 2005a), a trend that is called the healthy immigrant effect. This health advantage has been observed amongst immigrants to other countries such as the US (Antecol & Bedrad, 2005; Singh & Siahpush, 2002), Australia (Biddle, Kennedy & McDonald, 2007), and the UK (Kennedy, McDonald, & Biddle, 2006).

Some researchers (McDonald & Kennedy, 2004; Newbold, 2005a, 2006) argue that the healthy immigrant effect may be more apparent than real with respect to self-assessed health—for instance, Newbold argues that immigrants “re-evaluate their health relative to peers in Canada as opposed to the origin and/or as optimism declines and the reality of

immigrant life in the host country sets in” (2006, p. 781). Others note, however, that immigrants are less likely than the native-born populace to report a chronic condition (Chen et al., 1996a; Newbold, 2006; Perez, 2002), have a disability (Chen et al., 2006b), depression (Ali, 2002), or depressive symptoms (Wu & Schimmele, 2005a). Moreover, this advantage is especially observed in immigrants from non-European countries (Chen et al., 1996a, 1996b; Ng et al., 2005; Vissandjée et al., 2004).

The healthy immigrant effect is attributed to several factors: first, Canadian immigration policy selects for immigrants without serious medical conditions (Chen et al., 1996a; Dunn & Dyck, 2000; Hyman, 2001, 2004, 2007, 2011; Kennedy et al., 2006; Laroche, 2000; McDonald & Kennedy, 2004; Ng et al., 2005); second, immigrants may engage in relatively healthier behaviours in their home country prior to immigration (Kennedy et al., 2006); and third, self-selection, which means that people in good health are more likely to move and emigrate (Chen et al., 1996a; Hyman, 2001, 2004, 2007, 2011; Kennedy et al., 2006; McDonald & Kennedy, 2004; Ng et al., 2005).

As argued before, after settling, this advantage declines over time (Antecol & Bedrad, 2005; Chen et al., 1996a; De Maio & Kemp, 2010; Gee et al., 2004; Kim, Carrasco, Muntaner, McKenzie, & Noh, 2013; Newbold, 2005b, 2006, 2009; Ng et al., 2005; Perez, 2002; Vissandjée et al., 2004; Wu & Schimmele, 2005a); however, not all immigrants are equally likely to experience declining health status. In fact, non-European immigrants are twice as likely to report worsening health status (Ng et al., 2005) and women, particularly those from non-European countries, again, are more likely to experience a deterioration in their health (Kim et al., 2013; Vissandjée et al., 2004; Wu & Schimmele, 2005a).

## **Social Determinants of Health**

Some authors argue that deterioration in immigrants' health over time may be related to changes in their healthy behaviours after immigration (Antecol & Bedrad, 2005; Biddle et al., 2007) or exposure to environmental allergens (Biddle et al., 2007). However, the social determinants of health (SDH) approach suggests a shift from reliance on lifestyle behaviour as the most important predictors of health status to acknowledging economic and social conditions as the essential factors that influence health (Navarro, 2009; Raphael, 2004). In addition, SDH determine the extent and variety of resources that a society organizes and distributes to its members, and this approach contrasts with the biomedical perspective, which focuses upon individual behaviour (Raphael, 2004). The World Health Organization (WHO) defines the social determinants of health as:

[T]he circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics” (n.d., p. 1).

SDH consist of healthy child development, biology and genetic endowment, education and literacy, employment/working conditions, gender, income and social status, social support networks, social environments, the physical environments, personal health practices and coping skills, health services, and culture (Public Health Agency of Canada, 2011). The health of immigrants can be affected by determinants similar to those of non-immigrant Canadians; however, additional determinants related to migrant status also influence their health (Khanlou, 2010). Therefore, other determinants such as racism (Etowa & McGibbon, 2012; Hyman, 2009), and immigration have to be considered as health determinants for

immigrants (Hyman, 2004; Kinnon, 1999). Furthermore, Dunn and Dyck (2000) argue that the socioeconomic determinants of health are more important for immigrants than non-immigrants.

## **Employment**

In general, immigrants are better educated than Canadian-born population (Galabuzi, 2001; Kerr & Michalski, 2005; Zietsma, 2007). While educational attainment decreases unemployment rates for the Canadian-born, it has not been the case for immigrants (Kerr & Michalski, 2005; Zietsma, 2007). The employment gap between immigrants and their Canadian-born counterparts is well documented (Bauder, 2003; Block & Galabuzi, 2011; Galabuzi, 2001; Haan, 2008; Kerr & Michalski, 2005; Omidvar & Richmond, 2005, Yssaad, 2012; Zietsma, 2007) and dramatically demonstrates the impact of systemic racial discrimination in the labour market which is embedded in the white supremacist culture of Canada (Galabuzi, 2001). For instance in 2006, very recent immigrants—who landed in Canada five or less years prior to 2006—were more than twice as likely to be educated in comparison to the Canadian-born; however, their unemployment rate was more than double the rate for the Canadian-born populace (Zietsma, 2007).

While level of education is highly correlated with other SDH (Mikkonen & Raphael, 2010), due to a lack of recognition of education and credentials (Bauder, 2003; Danso, 2002; Galabuzi, 2001; Omidvar & Richmond, 2005; Spitzer, 2007, 2012; Swanton, 2005), immigrants “lose access to the occupations they previously held—an effect known as de-skilling” (Bauder, 2003, p. 701). In other words de-skilling “implies a forced removal or imposed loss of skills” (Alcuitas, Alcuitas-Imperial, Diocson, & Ordinario, 1997, p. 26). De-

skilling wastes human capital (Bauder, 2003); and also has traumatic emotional effects (Alcuitas et al., 1997; Bauder, 2003; Stafford, Newbold, & Ross, 2010). Bauder argues that many immigrants end up finding employment far below their qualification, which he terms “brain abuse” (2003, p. 714). In fact, immigrants’ education is not translated into income (Kazemipur & Halli, 2001). Employment not only provides income, but it is also a source of social support and networking and has correlation with self-esteem (Alcuitas et al., 1997; Pottie, Ng, Spitzer, Mohammed, & Glazier, 2008; Swanton, 2005). It represents “a means for identity formation, and provides a sense of belonging” (Galabuzi, 2012, p. 101).

### **Income**

Since the last decades low income rates have been rising among immigrants. According to the census data, in 1980 very recent immigrant men earned 85% of their Canadian-born counterparts; this number would fall to 65% in 2005 (Picot, Lu, & Hou, 2009). Generally speaking, dismissal of education and credits, particularly exclude newcomers from the upper segments of the labour market (Bauder, 2003) and immigrants are overrepresented in the lowest and lower middle-income quintile (Dunn & Dyck, 2000, Kazemipur & Halli, 2001). The poverty rates for racialized minorities who are recent immigrants, are higher (Galabuzi, 2001; Haan, 2008; Kazemipur & Halli, 2000, 2001). For instance, the 2006 census showed that the poverty rate for racialized individuals was 22% compared to 9% for non-racialized persons. Ninety percent of racialized individuals living in poverty were first generation immigrants (National Council of Welfare, 2012). In addition, the “colour coded labour market” and earning gaps persist for second-generation Canadians (Block & Galabuzi, 2011; Pendakur & Pendakur, 2011).

Census data suggest that during the last decades, the racialized population of Ottawa has also increased—from 11.5% in 1995 (Galabuzi, 2001) to 20.2% in 2006 (City of Ottawa, 2010). However, relative to their numbers in the general population, they disproportionately represent 50% of city's poorer citizen (City of Ottawa, 2010).

Living in the environment of poverty exposures individuals to adverse and cumulative social and physical stressors that can influence the health (Evans & English, 2002). Poverty also affects access to housing and food security (Hankivsky, 2007; Mikkon & Raphael, 2010; Vissandjée & Hyman, 2011). Studies indicate that living in poverty is associated with higher rates of heart attack, adult-onset diabetes (Mikkon & Raphael, 2010), serious illness, premature death (Wilkinson & Marmot, 2003), disabling conditions, psychiatric morbidity (Lorant et al., 2003), depression, stress, shame (Belle & Doucet, 2003; Reid, 2007), and low self-esteem (Spitzer, 2005).

Furthermore, chronic stressors of poverty may trigger the mobilization of coping strategies—engaging in unhealthy behaviours (Belle & Doucet, 2003; Evans, & English, 2002; Reid, 2007) like smoking or disordered eating, which influence the health and wellbeing of immigrant women (Reid, 2007). Finally, poverty can lead to poorer access to health services (Belle & Doucet, 2003; Reid, 2007; Lorant et al., 2003). Considering that prescription medications and some other services are not covered by the Canada Health Act, the ability to afford costs varies with income (Varcoe, Hankivsky, & Morrow, 2007). The cost of transportation, time away from work, and child-care illustrates additional layers of relation between income and inequities in access to health care (Eagan & Gardner, 1999; Etowa & McGibbon, 2012).

Two studies confirm that Iranian immigrants in York (Parya Trillium Foundation, 2012) and Vancouver (Swanton, 2005) have also faced with the similar barriers, like non-recognition of their credentials and unemployment or underemployment, which have been a source of financial and emotional stress. While 65% of survey respondents in York had post-secondary education, 85% of participants were not working in their field of education.

### **Racism and Discrimination**

Racism is a determinant of health (Krieger, 2003) that generates stress, and stress itself has a great impact on health (Brondolo, ver Halen, Pencille, Beatty, & Contrada, 2009; Carter, 2007; Galabuzi, 2004). In fact, directly through psychological and physiological stress responses, racism influences health (Hyman, 2009; Veenstra, 2009). Furthermore, racism can indirectly affect health, through differential opportunities related to other SDH (Brondolo, Love, Pencille, Schoenthaler, & Ogedegbe, 2011; Danso, 2002; Hyman, 2009; Krieger, 1999; Nazroo, 2003; Williams, 1997). De-skilling, labour market segregation, and economic and social hardship are part of immigrants' experiences of what Essed has termed "everyday racism" (as cited in Etowa & Gibbon, 2012, p. 81). Therefore, "[t]he 'racialization of poverty' compounds inequalities in material conditions in socially excluded communities" (Galabuzi, 2004, p. 235).

Studies reveal that both interpersonal and institutional racism may increase risk for hypertension (Brondolo et al., 2011; Krieger & Sidney, 1996), as well as depressive symptoms (Beiser, 2009; Levy, Ansara, & Stover, 2013; Noh, Beiser, Kaspar, Hou, & Rummens, 1999). In Canada, racism has been embedded not only in the country's policies and institutions, also but has been documented in interpersonal discrimination. According to

Canadian police services, in 2010 the two most common motivations for hate crimes were race/ethnicity (52%) and religion (29%) (Dowden & Brennan, 2012).

Moghissi mentions that Iranian women like all other immigrant women have suffered from painful racial structures in their adopted home-countries (1999). For instance, researchers in Sweden discuss that “ethnic discrimination” has been the “greatest problem” for Iranian immigrant women (Akhavan, Bildt, & Wamala, 2007, p. 354). In Canada, Iranian immigrant women have reported sharp declines of socio-economic satisfaction, and this dissatisfaction and structural discrimination have a great impact on a sense of not belonging (Moghissi et al., 2009).

### **Social Support Networks**

Evidence suggests that increasing the density of immigrants who are from the same ethnicity in a neighborhood has a positive relationship with mental health (Stafford et al., 2010; Xu & McDonald, 2010). Noh and Avison (1996), in examining Korean immigrants, argue that social support from members of the same culture made greater contributions to immigrants’ health and wellbeing than support from the broader community, and also reduced levels of stressful life events. Building on the works of Berkman et al. and House et al., Shields argues “that feeling ‘connected’ to one’s community promotes health because such ties promote mutual respect, and thereby increase self-esteem” (2008, p. 1). Moghissi argues that Iranian women find it difficult to develop meaningful friendships outside their own culture. In addition, by losing all-female networks “uprootedness means a loss of security and support which they enjoyed at home” (1999, n.d.).

## **Age**

Studies demonstrate that age at arrival is an important factor in mental health and wellbeing (Canadian Task force, 1988; Xu & McDonald, 2010). For instance, Wu and Schimmele argue that immigrants who had landed in Canada before age 18 had worse mental wellbeing than other immigrants (2005a). Immigrants who migrate in adolescence are often caught between different cultures and must deal with their own specific challenges (Morris, 2003; Wu & Schimmele, 2005a). Jiwani (2006) argues that acculturation is highly gendered and young women show a higher rate of dissatisfaction with their communities in comparison to their male counterparts. Acculturation not only affects the first generation of immigrant women, but it also influences the second generation (Rajiva, 2009).

A study in Vancouver conducted by Jafari, Baharlou, and Mathias (2010), revealed that young Iranian adult participants' main concern was their parents' resistance to accepting new social norms. The disagreement between parents and children on sexual behaviours was one of the main issues of conflict. The social service providers in York study also mentioned that cultural clashes had been an issue while working with the Iranian newcomer youths (Parya Trillium Foundation, 2012).

For immigrants who are 45 years old and over, the employment rate is much lower than younger immigrants (Grondin, 2007); the relationship between employment and health was described earlier. Additionally, studies report that for elderly Iranian participants, the major problems were poor social and family support, lack of language proficiency (Jafari et al., 2010), lack of transportation assistance to ESL classes, difficulty finding employment at older age with language barrier, and feeling like burdens for who gained entry to Canada as

dependent upon their children through sponsorship programs (Parya Trillium Foundation, 2012). Shemirani & O'Connor (2006) through semi-structured interviews documented the aging experiences of five Iranian women (three of whom came as refugees/refugee claimants) who immigrated to Canada after age 45. Three themes emerged from researchers' findings: lacking control over migration, experiencing multiple losses, and avoidance and fear of aging. Dossa's study on Iranian immigrant women also supports the rupture of intergenerational relationships that, she argues, can be a potential source of depression (1999). Ghorashi asserts that for older people it is more difficult to adopt a new language and lifestyle (2003). Researchers in Sweden suggest that community intervention programs such as pot-lucks, playing bingo, cultural events, and poetry reading in a day care centre for Iranian immigrant seniors can reduce isolation and stress, and have a positive impact on the elder's health and wellbeing (Emami, Torres, Lipson, & Ekman, 2000). Researchers in Australia found that Iranian immigrants over the age 65 were more likely to have psychological distress than their Australians counterparts (Alizadeh-Khoei, Mathews, Hossain, 2011).

### **Health Services**

Health care services are not only one of the SDH, but they are also a fundamental human right (Mikkonen & Raphael, 2010). Deri (2005) argues that recent immigrants use physician services less frequently than non-immigrants or long-term immigrants and this difference in utilization is largest for preventive services. Hyman also found similar patterns of underutilization in the use of preventive and mental health services among recent

immigrants (2001) and underutilization of preventive health screening may impact health in a negative way (Hyman, 2009; Newbold, 2005b).

Moreover, other issues like trust of Western medicine and the preferential use of traditional and alternative treatment can affect health services utilization. For instance, Chen (2010) mentions; “[e]xisting mental health services, which are built around the medical model, are often not appropriate or acceptable” (p. 51). In addition, traditional treatment is usually not covered by health plans which can make another barrier (Chen, 2010; Lee, Rodin, Devins, & Weiss, 2001). Furthermore, research indicates that health services utilization increases with the number of physicians who speak the same language in the neighbourhood (Deri, 2005). This is consistent with the results of a study on Iranian immigrants which shows that the participants preferred to receive sexual health education and information from a physician who was fluent in Farsi and familiar with their culture (Maticka-Tyndale, Shirpak, & Chinichian, 2007). Another study in the Greater Vancouver Area also supports the previous study and reveals that creating and airing culturally sensitive programs, particularly by well-known providers in Iranians’ community, is an effective way for providing accessible health information (Poureslami, Rootman, & Balka, 2007).

Moreover, barriers to health care services can be stress-inducing in themselves (Ahmad, Shik, et al., 2004). Various studies reveal many challenges facing immigrants. The barriers include: language insufficiency (Ahmad, Shik, et al., 2004; McKeary & Newbold, 2010; Ng & Newbold, 2011; Oxman-Martinez et al., 2000; Reitmanova & Gustafson, 2007, 2008; Stewart et al., 2008), limited knowledge about available services (Ahmad, Shik, et al., 2004; Donnelly & McKellin, 2007; Reitmanova & Gustafson, 2007), long waiting periods to see specialists (Ahmad, Shik, et al., 2004; Ng & Newbold, 2011; Reitmanova & Gustafson,

2007), shortage of health care services (Dean & Wilson, 2010; McKeary & Newbold, 2010), lack of control in the referral process, three-month waiting period for health insurance in some provinces (Ahmad, Shik, et al., 2004), health care coverage (McKeary & Newbold, 2010), cultural/religious barriers (Jiwani, 2006; McKeary & Newbold, 2010; Reitmanova & Gustafson, 2007, 2008), lack of same-sex providers (McKeary & Newbold, 2010; Ng & Newbold, 2011; Weerasinghe & Mitchell, 2007), expense and/or difficulty in finding close parking (Neufeld, Harrison, Stewart, Hughes, & Spitzer, 2002) and discrimination (Jiwani, 2006; McKeary & Newbold, 2010; Reitmanova & Gustafson, 2008). More importantly, it is more likely for women than men that their care needs go unmet (Armstrong, 2004).

Some of these findings are consistent with the research on Iranian immigrants; three-month waiting period for health insurance—particularly for seniors (Parya Trillium Foundation, 2012), long wait times to get a referral (Dastjerdi, 2007; Maticka-Tyndale et al., 2007), language barrier (Dastjerdi, 2007, 2012, Dastjerdi, Olson & Ogilvie, 2012; Maticka-Tyndale et al., 2007), lack of knowledge of Canadian health care services, lack of trust in Canadian health care services (Dastjerdi, 2007, 2012, Dastjerdi, Olson & Ogilvie, 2012), inability to afford the cost of medications and eye or dental care (Dastjerdi, 2012), and discrimination (Dastjerdi, 2007; Dastjerdi, Olson & Ogilvie, 2012).

## **Culture**

As Lipson mentions, “health conceptions are culturally influenced” (1992, p. 18), therefore immigrants may have different health knowledge and health care experiences (Simich, 2010). In fact, health is more than “an objective biological phenomenon”; it “is culturally defined and practiced” (Agnew, 2009a, p. 95). By assessing breast health

knowledge of Iranian immigrant women, Vahabi (2011) shows that Iranian women had a limited preventive knowledge. She argues while immigrant women's health practices could be shaped by their homeland values and their cultural attitude, it is necessary for health care professionals to be educated about the needs of immigrant clients and to notify women when they are due for the annual check-up.

Poureslami et al. mention that many Iranians, especially elders, tend to ask for advice when they are seriously ill and Iranian culture does not traditionally emphasize preventive health care (2007). Lipson's findings (1992) in the United States show that some Iranian immigrant participants of her study used home remedies like teas or herbs for prevention and treatment of symptom such as nervousness or stomach upset, and most of them were reluctant to seek psychiatric help; rather they preferred to solve their problems by themselves or discuss it with family members. Researchers in Canada (Dastjerdi, 2012) and U.S. (Lipson, 1992) argue that different expectations between health care providers and Iranian immigrants can lead to dissatisfaction.

While calls for culturally competent care have been on the rise, their effectiveness in reducing health inequalities is in doubt (Edge & Newbold, 2013, p. 145; Etowa & McGibbon, 2012, p. 86; Reitmanova & Gustafson, 2008, p. 102). In fact, addressing the issue of cultural sensitivity may detract attention from political, social, and economic factors that exclude the concerns of racialized immigrants (Dossa, 2004).

## **Language**

After finding an appropriate job, the language barrier was the second-ranking difficulty reported by immigrants (Grondin, 2007). Language proficiency not only limits access to health care, but it is also a predictor of employment and income (Beiser & Hou, 2000); as well as an ability to build relationships and healthy social support systems (Vissandjée et al., 2007). While language proficiency is an important part of human capital (Grondin, 2007), women have had fewer opportunities than men to learn language during post-migration period (Beiser & Hou, 2000). Priority of language training in immigrant families may be given to men in order to upgrade their skills to find a job and after years when women find an opportunity to participate in language training programs, these programs are not free and may be not affordable for them because of economic difficulties (Morris, 2003). This is important, particularly when studies such as Pottie et al.'s (2008) show that poor language proficiency is associated with poor-self reported health and this association primarily impacts women. For example, for Iranian immigrants in York, the long waiting list for governmental funded language classes and shortage of evening classes—for those who were unable to attend day-time classes—were important concerns (Parya Trillium Foundation, 2012).

## **Physical Environments, Living and Working Conditions**

The physical environments, living and working conditions influence health in many ways. For instance, overcrowding is a predisposing factor for respiratory infections. Moreover, poor housing such as inadequate heating and ventilation, because of socioeconomic status, have adverse health outcomes (Mikkonen & Raphael, 2010). These conditions may cause accumulation of toxins from household cleansers or home cooking,

which have significant impact on the health of women (Spitzer, 2005). In addition, occupational or ergonomic exposures may jeopardize immigrant women's health (Spitzer, 2005); particularly when they are more likely to work for "survival jobs" (Spitzer, 2011b, p. 27), in low skill and manual jobs which have poor occupational health standards (Benoit & Shumka, 2009; Galabuzi, 2001; Premji, Duguay, Messing, & Lippel, 2010; Spitzer, 2011b). For example, a study shows (Ahmad, Shik, et al., 2004) that some immigrant women were suffering from back pain due to the labour they had to do in Canada.

Similar patterns were observed in the York study; many Iranian newcomers were working in survival jobs and numerous immigrant men left Canada for better employment opportunities and income, which places a considerable amount of mental and physical stress on the other parent and on the children (Parya Trillium Foundation, 2012). In another study, some Iranian immigrant women mentioned that growing air pollution in Iran, particularly in Tehran, was one of the reasons for their migration. Some also chose Vancouver for its mild climate and geographical similarities with Iran (Bailey, 2004). Comparing leftist activist refugee Iranian women in California and in the Netherlands, Ghorashi (2003) argues that familiar surroundings made the adjustment easier for women in California; while, most of women in the Netherlands complained about the cold.

## **Refugees**

The suddenness of displacement (Danso, 2002) and pre-migration experience (Beiser, 2009; Oxman-Martinez et al., 2000) are important factors that influence health/wellbeing of refugees (Beiser, 2009; Danso, 2002; Oxman-Martinez et al., 2000). Many of them suffer from the loss of all contact to the countries they fled (Malkki, 1995), which can affect their

health (Grove, & Zwi, 2006). At time of arrival, the health of refugees might be worse than other types of immigrants (Perez, 2002) due to the less precise screening process that refugees undergo (Kinnon, 1999) as well as their previous experiences of trauma (Grove, & Zwi, 2006; Kinnon, 1999). Pre-migration trauma can also jeopardize refugees' health after arrival (Beiser, 2005) and they are more likely to decline to a state of poor health (Newbold, 2009) and have greater health needs (McKeary & Newbold, 2010). Moreover, refugees are often portrayed as a drain on resources (Grove, & Zwi, 2006) and discrimination affects their health (Beiser, 2009). In the UK, refugee women were more likely to experience depression in comparison to male refugees (Drennan & Joseph, 2005). A study by Bagheri reveals that 10% of Iranian patients in Canada who were referred for psychiatric treatment had experienced pre-migration trauma due to war or the Revolution (1992).

### **Gender**

As discussed earlier, gender is a determinant of health (Spitzer, 2005, 2009; Varcoe et al., 2007) and is determined by an unequal power structure that affects all aspects of women's lives (Boyd & Grieco, 2003; Ll  cer, Zunzunegui, del Amo, Mazarrasa, & Bol  mar, 2007). Women are more likely to exert less control over their bodies, or to be poor (Benoit & Shumka, 2009). In addition—as mentioned before—women have more responsibilities for taking care of the household and for raising children that cause stress and strain (Mikkonen, & Raphael, 2010, Oxman-Martinez et al., 2000; Spitzer, 2005; Stacey, 2005; Varcoe et al., 2007). Furthermore, during the last decades, work-life conflict has increased dramatically and women experience higher levels of this conflict than men do: mothers continue to experience more stress and greater conflict between their family and work than do fathers

(Duxbury & Higgins, 2001, 2003) and the relation between this conflict and health problems is well documented (Duxbury & Higgins, 2001, 2003; Frone, 2000).

Migration constitutes both potential challenges and opportunities (Dossa, 2004; Llácer et al., 2007; Spitzer, 2007; Vissandjée et al., 2007). Negotiation of new gender and familial roles (Boyd & Grieco, 2003; Mahdi, 1999; Spitzer, 2007, 2011a), as well as losing their previous family and community networks, can affect the lives of immigrant women (Dossa, 2004; Spitzer, 2007).

Additionally, immigrant women are more educated than their Canadian-born counterparts and in 2006, 26% of them had a university degree (Chui, 2011); however, the employment rate for the very recent immigrant women was near three times lower than the Canadian-born women (Zietsma, 2007). Moreover, immigrant women are more likely to experience a significant degree of employment mismatch, and the prevalence of this trend increases with age (Haan, 2008). In addition, negative effect of unemployment is stronger for women (Bambra, & Eikemo, 2009).

Furthermore, the lack of subsidized child care (MacDonnell, Dastjerdi, Bokore, & Khanlou, 2012; Piano, 2014; Rasouli, Dyke, & Mantler, 2008) or culturally appropriate child care (City of Ottawa, 2010) can create another obstacle for immigrant women, particularly for single mothers (City of Ottawa, 2010), to find employment. The lack of subsidized child care can also be a barrier when women are seeking higher education (Rasouli et al., 2008). Moreover, if they find a job, they may interrupt it for caretaking, which can lead to poverty in their old age (Anderson, 2000). A study reveals that Muslim women who wear hijabs

experienced discrimination when applying for works or harassed in their workplace (Persad, & Lukas, 2002).

Moreover, “poverty and low income are gendered phenomena” (Reid, 2007, p. 201). In 2005, immigrant women earned less than both Canadian-born women and their male counterparts (Chui, 2011). In 2006, the rate of poverty was higher for racialized women than their male counterparts; 52% versus 48% (National Council of Welfare, 2012). In that year, racialized immigrant women earned 56.5 cents for every dollar that non-racialized men earned.

Low income is much higher for lone-parent families (Kerr & Michalski, 2005; Haan, 2008), the majority of them mothers rather than fathers (Kerr & Michalski, 2005). For instance in 2010, lone-parent families were three times more likely to be poor than two-parent families with children (Citizen for Public Justice [CPJ], 2012) and this rate increased to almost four times in the next year—85% of poor lone-parents family were female-led (CPJ, 2013). Furthermore, lone-parent women are more likely to report depression than other women (Stewart, Gucciardi, & Grace, 2003).

Women are also more likely to experience severe and chronic patterns of violence and coercive control involving high levels of injury than men (Ansara & Hindin, 2010). Migration may increase immigrant women’s vulnerability to experiencing harmful expressions of patriarchy (Ahmad, Riaz, Barata, Stewart, 2004; Moghissi, 1999), because they may encounter economic, cultural, and linguistic barriers to accessing support; as well they may distrust or fear the Canadian legal system (McDonald, 1999; Thurston, 2011). Among them, the immigrant women who gain entry to Canada as dependent spouses or

dependent upon their employers through sponsorship programs, are more vulnerable to abusive relationships (Cottrell, Tastsoglou, & Moncayo, 2009; Johnson & Colpitts, 2013).

Iranian immigrant women similar to the other immigrant women have also experienced unemployment and economic decline and their unemployment rates are higher and their income is lower than their male counterparts (Moghissi et al., 2009). Dossa, in her study of post-revolution Iranian women living in metropolitan Vancouver, argues that the social experiences of Iranian immigrant women are compounded by both surviving the revolution and dealing with Canadian immigration policies. She mentions that the Canadian system “erased” some Iranian women’s professions and there was a “downward mobility to its lower level” (2004, p. 96). She explains that women’s “structural isolation and social invisibility deprives them of the opportunity to engage in what should be the basic human rights: the right to work and to seek opportunities for social interaction” (p. 167).

In addition, family has a central role in Iranian society (Mahdi, 1999; Naghdi, 2010; Shirpak, Maticka-Tyndale, & Chinichian, 2011). Mahdi argues that the role adjustments for women who immigrated to the United States, are accompanied by satisfaction, as well as high degrees of stress (1999). Moreover, studies in the U.S. (Mahdi, 1999) and Canada (Shahidian; 1999; Shirpak, Maticka-Tyndale, & Chinichian, 2007) show that the prevalent individualism and greater focus on the rights of the individual are antithetical to the collectivist tendencies that are present in the Iranian family and can be seen as a potential threat to Iranian marriages and as a contributor to high divorce rates. Other studies also confirm the highest rate of divorce among Iranian immigrants in comparison to other communities: the highest rate among four communities in Canada (Moghissi et al., 2009), and the second highest rate in Sweden (Naghdi, 2010).

## **Disability**

People with disabilities are more likely to experience lower educational achievements, less economic participation, poorer health outcomes, and higher rates of poverty than the general population (DesMeules, Kazanjian, Payne, Stewart, & Vissandjée, 2003; WHO & World Bank, 2011; Wiebe & Keirstead, 2004). They are also more likely to have long-term poverty (CPJ, 2013) and duration of poverty is another factor that influences health (CPJ, 2012). Moreover, while women have a longer life expectancy than men, they experience more episodes of chronic conditions and long-term disability than men (DesMeules et al. 2003; Mikkonen & Raphael, 2010).

With regards to Iranian immigrants, research in Belgium shows how the combined forces of history, religion and rejection, unemployment, and discrimination excluded Iranian immigrant with disabilities from their new host country (Albrecht, Devlieger, & Van Hove, 2009). And in reference to Fahimeh, an Iranian woman living with disability in Canada, Dossa (2006) notes that:

a familiar social environment helped her to avoid wearing the label of disability as the sole marker of her identity.... This situation was reversed upon her migration to Canada. Though labelled as disabled, she was not entitled to access resources owing to compounded marginalization resulting from her being a disabled woman of colour (p. 350).

## **Sexual Orientation**

While lesbian and bisexual women have the similar range of social and health concerns and no illness unique to them, they face discrimination and isolation as the result of their sexual orientation (Mathieson, 2007; O'Neill & Sproule, 2011). For immigrants, “coming out may contradict values in some cultural contexts” which might lead to feeling excluded from their communities (O'Neill & Sproule, 2011, p. 70). Moreover, due to societal attitudes grounded in heterosexist beliefs, lesbian and bisexual women need to disclose or negotiate their identities with health care providers. Disclosing can make them uncomfortable, so they do may decide not to seek care. Furthermore, research shows that women may face homophobic attitudes from health care providers (Mathieson, 2007). Discrimination is amplified when being bisexual or lesbian is compounded by other identities such as racialized/ethnic identity (Mathieson, 2007).

## **Conclusion**

The literature review shows that most of the studies that have examined the Iranian immigrants' health focused on one of the health determinants or did not explain the intersection of racialized status, gender, migration experience, and socioeconomic determinants. Dossa emphasizes that in order to find the factors that affect wellbeing, it is vital to see beyond barriers at the individual level (2004) and examine the multiple structural exclusions and “the different ways in which social markers of difference play out in particular contexts” (2006, p. 347). Importantly, most of these studies did not explore the health status' change after immigration or conceptualize the meaning of health based on the voices of Iranian immigrant women. Furthermore, the majority of the existing research took

place in Toronto or Vancouver and to the best of my knowledge, no study has been conducted in the Ottawa/Gatineau region. While there have been “some signs that recent immigrants are choosing to settle in smaller metropolitan areas” (Chui et al., 2007, p. 5), the need for understanding the experiences of smaller urban centres has remained (Edge & Newbold, 2013). In addition, the Iranian community as a relatively new community does not have significant level of cohesion (Rahnema, n.d.), so it is reasonable to assume that “the ‘protective’ urban effect” (Malenfant, 2004, p. 14) may not extend to a smaller region like Ottawa/Gatineau.

The aim of my study is to address these gaps; moreover, the voices of Iranian immigrant women living in Ottawa/Gatineau need to be heard in order to not only find the individual levels’ health determinants but also to investigate the political, social, and economic determinants of their health.

## Chapter Three: Theoretical Framework

In this chapter, I present the conceptual and theoretical approaches underpinning my investigation of the perceptions and experiences surrounding the impact of immigration on the health/wellbeing of Iranian immigrant women.

Canada is well-known for its relatively high standard of health and living; however, these standards are not distributed across the population—particularly for women disadvantaged by various forms of oppression. Examining these inequities demands a critical analysis and a comprehensive framework which understands gender as a significant determinant of health but one that is inseparable from other forms of social indicators such as class, sexual orientation, disability, age and ethnicity/racialized status (Varcoe et al., 2007). Indeed, there are numerous social identities that interact, reinforce, and mutually constitute one another (Dhamoon & Hankivsky, 2011; Hankivsky & Cormier, 2009; Shields, 2008) to influence health and wellbeing (Varcoe et al., 2007; Spitzer, 2011a, 2011b).

Moreover, this framework has to consider traditional health determinants, such as genetic and biological factors (Hyman, 2011)—as we cannot deny the material reality of biology (Singer, 2004)—and other determinants of health; as well as related determinants to the migration context, such as migration policy (Hyman, 2011). Indeed, considering migration experience shows “another layer of complexity to the multiple pathways through which the determinants of health operate” (Bierman et al., 2009, p. 98). Therefore, women’s health is a multidimensional issue (Morrow & Hankivsky, 2007) and analysis of immigrants’ health needs an integrated, multilevel, and intersectional approach (Ingleby, 2012).

To do this, I use intersectionality as a theoretical framework and engage with two concepts: the social determinants of health and oppression to explore the interactions between social determinants of health and various forms of oppression that impact Iranian immigrant women's health and constitutes their complex social landscape. Before moving to intersectionality, I attempt to unpack the linkage between the social determinates of health and multiple oppressors that affect health and wellbeing.

### **Social Determinants of Health: A Critical Perspective**

Over a century and a half ago, Rudolf Virchow, a German physician, investigated the epidemic of typhus in Upper Serbia and Frederick Engels, a political economist, studied the health conditions of British working class. Both argued that unfair policies and economic status related to material conditions of life—poor living conditions, inadequate diet, and lack of sanitation—and they also described the direct links between social conditions and health (Navaroo, 2009; Raphael, 2004). These researchers—among many others who have followed their works—show that several social and economic interrelated conditions, beyond individual behaviour determine health and wellbeing of individuals (Navaroo, 2009; Raphael, 2004, 2012).

Therefore, the social determinants of health approach is a critical examination of the complex web of determinants that influence the health and wellbeing of a population, as well as analyzing the unequal distribution of various resources that are offered and made available by a society (Raphael, 2004, 2006, 2012). In this view as Virchow eloquently pointed out, *“Medicine is a social science and politics is nothing else but medicine in large scale”* and for fulfilling her task, medicine *“must enter the political and social life”* (as cited in Raphael,

2004, p. 3). As Raphael argues, working on social determinants of health needs “a master conceptual scheme” from a “critical social science” perspective to illuminate the social, economic, and political processes by which inequity to access to social determinants of health is shaped (2006, p. 654).

## **Oppression Illness: Anti-oppression Lens**

Moving from biological to social understanding of health is fundamental to making linkages between the processes of oppression and structural discrimination, and health and wellbeing (McGibbon, 2012b; Singer, 2004). Along with chronic worrying about basic necessities such as shelter and food—as a result of unequal distribution of social determinants of health—which leads to psychological stress and chronic anxiety (McGibbon, 2012a; McGibbon & McPherson, 2011), everyday sexism and racism, to mention a few, cause the mental, spiritual, and physical suffering (McGibbon, 2012a).

To draw attention to the social origin of illnesses, Singer (2004) offers the term “oppression illness” which “is used to label the chronic, traumatic effects of experiencing social bigotry over long periods of time (especially during critical developmental periods of identity formation) combined with the negative emotional effects of internalizing prejudice” (p. 17). In this vein, an oppressive environment and negative social stereotypes about gender, ethnicity, sexual orientation, and other identities is a source of stress which produces an illness. Indeed, oppression encompasses the health effects of social and material deprivation, social exclusion, and stigma as expressed through the chronic psychological and physical stress that ultimately leads to mental and physical problems (McGibbon, 2012b; Singer, 2004).

In other words, oppressions are “part of a complex set of structural imperatives that determine how society is organized through key institutional arrangements that shape the distribution of benefits and burdens” (Galabuzi, 2012, p. 97). The threats of oppression, unequal distribution of resources, and deprivation are articulated through a complex network of social determinants of health, leading to policy-based illnesses (McGibbon, 2012b).

Therefore, to enrich an understanding of how social determinants of health as well as different forms of discrimination, and hence oppression operate—in a complex manner to shape and impact on the health of Iranian immigrant women, I use intersectionality as a comprehensive framework. This framework explores multiple axes of difference and recognizes the ways in which Iranian immigrant women experience the world from their particular social location through mutually constitutive interactions of different social indicators. Furthermore, individuals’ lives reveal that there are multiple identities that shape their experiences, so intersectionality also reflects the reality of life (Shields, 2008).

### **Intersectionality: Theoretical Framework**

According to the Association for Women’s Rights in Development,

Intersectionality is a feminist theory ... [which] starts from the premise that people live multiple, layered identities derived from social relations, history and the operation of structures of power. Intersectional analysis aims to reveal multiple identities, exposing the different types of discrimination and disadvantage that occur as a consequence of the combination of identities. It aims to address the manner in which racism, patriarchy, class oppression and other systems of discrimination create inequalities that structure the relative positions of women. It takes account of historical, social and political

contexts and also recognizes unique individual experiences resulting from the coming together of different types of identity (2004, pp. 1-2).

Hankivsky (2012) argues that intersectionality emphasizes the potential integrated and fluid configurations of the complex interplay amongst social locations and processes that shape health inequalities. It “is not an additive approach” (p. 1713), instead it “rejects hierarchical ordering of oppression” (p. 1715). In other words, intersectionality “is based on a number of key assumptions concerned with the simultaneous nature of multiple categories at multiple levels” (Hankivsky et al., 2010, p. 2). It is a multi-level analysis that “pays heed to the combination of forces arising from *micro*-, *meso*-, and *macro*-levels of society” (Guruge & Khanlou, 2004, p. 34). In addition, intersectionality is the prevailing approach to examining the dynamics of differences and similarities (Cho, Crenshaw, & McCall, 2013; Shields, 2008; Varcoe et al., 2007) and not homogenizing all members of a group (Hankivsky & Cormier, 2009).

Moreover, intersectionality is a critical framework that has revealed policy is not only neutral but it also “reifies the oppressive consequences of intersecting social locations” (Hankivsky & Cormier, 2011, p. 219). According to Nash, intersectionality is an analytic tool for theorizing oppression (as cited in Hankivsky & Cormier, 2011, p. 217). While oppression, power, and discrimination are interconnected and structural power is at the heart of oppression (McGibbon, 2012a), intersectionality pays explicit attention to power and interrogates its dynamics (Cho et al., 2013; Dhamoon & Hankivsky, 2011; Hankivsky & Christoffersen, 2008; McGibbon & McPherson, 2011; Morris & Bunjun, 2007; Tomlinson, 2013; Wilkinson, 2003).

Therefore, employing intersectionality as a critical feminist framework and utilizing an anti-oppression lens permits me to see how structural barriers and systemic practices may impact the health/wellbeing of Iranian immigrant women. In the time health inequities particularly persist for women who are disadvantaged by multiple forms of oppression, analysis of these inequalities demands a focus on social and economic circumstances, which are not separable from gender and other forms of social difference (Varcoe et al., 2007). While looking at the social determinants of health will move my thoughts from “the cell to the social” (Leeuw & Greenwood, 2011, p. 54), an anti-oppression critical perspective will help me to investigate the “causes of causes” (McGibbon, 2012a, p. 16) and the effects of systemic discrimination and oppression on wellbeing. To put it in another way:

We must relinquish the reductionist lens of the medical gaze in favour of a more complex consideration of im/migrant health that can be situated within a dynamic social context that attends to the social environment, the political economy of health and the body — in essence, a platform upon which we can examine the impact of marginalization and oppression on well-being (Spitzer, 2012, p. 114).

In fact, intersectionality is a different way of thinking that shows how the systems of oppression operate together to grant power and privilege (Garland-Thompson, 2002). This framework leads researchers to consider broader structural and systemic inequalities (Berman et al., 2009).

For Jiwani, “[i]ntersectionality is a key concept [in] navigating this maze of crosscutting, intertwining, and intermeshing conduits of domination” (2006, p. 16). While “health is a social justice issue” (Reid, 2007, p. 215), this framework helps me to “walk through the path of social justice and to tread [my] way through the complexities of power

relations” (Razack 1998, p. 22). In fact, one of the main aims of intersectionality is the pursuit of social justice (Hankivsky & Cormier, 2011; Wilkinson, 2003) which is the mission of feminist researchers (Hesse-Biber, 2012).

Moreover, Iranian immigrant women like other immigrants “are not passive tools of fate” (Beiser, 2005, p. S39) and they respond to the challenges. As Dossa (2009) mentions, a “pluralistic approach can lead to a more enhanced understanding of the workings of power (structure) and the ways that people remake their worlds (agency)” (p. 156). Finally, interrogating multiple forms of exclusion allows me to have a sharper political edge (Dossa, 2009).

To conclude, various determinant factors operating at different levels, from individual (micro) level to intermediate (meso) level and systemic (macro) level, determine the health of immigrant women. These factors intertwine and mutually constitute one another. In other words, these factors cannot be considered as simple predictors of wellbeing and health, “but rather should be seen as producing a dynamic matrix of dominant and subordinate positions within the social landscape” (Spitzer, 2009, p. 138). Therefore, my thesis looks at the complex ways in which migration, gender, racialized status, and other social identities, intersect with other determinants of health to shape health/wellbeing of Iranian immigrant women.

## Chapter Four: Research Activities

In this chapter I describe the methodological undertaking and research activities of this research.

### Methodology

Methodology is “‘a shared quest for the way to truth,’ ‘a shared account of truth,’ or ‘the way a group legitimates knowledge claims’” (Hawkesworth, 2012, p. 93). Harding defines methodology as “a theory and analysis of how research does or should be proceed” (1987, p. 3). It provides the theoretical perspective that joins the research question to a specific method or methods (Hesse-Biber, 2010). In other words, methodology provides “the philosophical or logical rationale for the links researchers make among theory, pragmatic research strategies, evidence, and the empirical world” (Harrison, 2007, p. 25). Feminist methodology seeks to find “what is not there and hear what is not being said” (Code, 1995, p. 23). Put it another way, “[f]eminist methodology is specifically concerned with how, or whether, knowledge produced about social life can be connected with the social realities of women” (Landman, 2006, p. 430). In fact, feminist methodology is rooted in the belief that knowledge is situated within the specific place and time, as well as cultural, historical, social, and political context (Beckman, 2014). Moreover, it tries to understand the power structures (Beckman, 2014; Code, 1995) because “there is a power element in the accreditation of knowledge” (Hawkesworth, 2012, p. 93). According to Code, “most knowledge-producing and knowledge-circulating activity is politically invested” (1995, p. 38). Indeed, one of the things that distinguishes feminist research is its methodology, which provides particular

principles to overcome biases; rather than use of a specific method (Beckman, 2014). Most importantly, the central mission of feminist research is striving to give voice to women's lives and other people who are ignored or silenced in order to uncover hidden knowledge (Brooks, 2007; Hesse-Biber, 2012). Therefore, I carry out my research "on behalf of women" (Hesse-Biber, 2012, p. 138), and "with women" to respect "the creativity, knowledge and leadership of women themselves" (Morris & Bunjun, 2007, p. 17).

### **Method**

For the purpose of this research I needed to propose a method that was "appropriate for the kind of question asked and the information needed and which permit answers pervasive to a particular audience" (Jayaratne & Stewart, 2008, p. 54). Since qualitative methods seek to find how people make meaning of their social world (Denzin & Lincoln; 2003a; Hesse-Biber, 2010) and while "knowledge comes from experience" (Belenky, Clinchy, Goldberger, & Tarule, 2008, p. 240), to achieve the research's aim and understanding of a particular viewpoint of Iranian immigrant women about the impact of immigration on their health/wellbeing, I used a qualitative method. Within the qualitative paradigm, I chose face-to-face, in-depth interviews as my data-collection tool, which is one of the most familiar methods for collecting qualitative data (DiCicco-Bloom & Crabtree, 2006). Human beings live in a conversation society and dialogue is a basic mode of our interactions (Denzin & Lincoln; 2003b; Fontana & Frey, 2003; Kvale, 2007), however; interviewing is a professional interaction—where knowledge is constructed as the result of this interaction—and its structure and purpose are determined by an interviewer (Fontana & Frey, 2003; Kvale, 2007).

In-depth interviews allowed me to explore the perceptions of Iranian immigrant women who are “experts on their own experience” (Darlington & Scott, 2002, p. 48). It is a great method for understanding a particular area of a person’s life (Hesse-Biber, 2007), realizing how people in relation to a given topic think (Darlington & Scott, 2002), and gaining access to people’s inner perceptions, attitudes, and feelings of reality (Zhang & Wildemuth, 2006) through their own words (Kvale, 2007). As Kvale (2007) suggests, I went through seven interdependent stages of the interview inquiry: thematizing, designing, interviewing, transcribing, analyzing, verifying, and reporting.

### **Thematizing**

Thematizing is an important part of an interview inquiry and is defined as formulating the purpose of the project and research questions, as well as the theoretical clarification of the themes examined, and the provision of the pre-knowledge of the content of an investigation through literature review and familiarity with the local situation and power structures. Most importantly, it is necessary for a researcher to have an extensive knowledge of the interview topic, without attempting to shine with this knowledge (Kvale, 2007).

Before embarking on my interview journey, I began to review the literature related to Canadian immigration history and policy, immigrant’s health and Iranian immigrant’s health—particularly in Canada—feminist theories and methodologies, and social determinants of health that would continue during the writing of my thesis. In addition, although as an Iranian I was familiar with the history, culture, and official language of Iran, I realized that I had to enhance my knowledge about this country.

## **Designing**

This stage involves planning the techniques and procedures to obtain the knowledge and take into account the moral implications of the research (Hesse-Biber, 2007; Kvale, 2007). I provided “open-ended questions within a predetermined set of topics” (Curry, Nembhard, & Bradley, 2009, p. 1445); notably, these questions were simple and brief (Kvale, 2007). I also designed a few sub-questions that were related to my main question. I wanted to cover these questions, but their order was not important. For this reason, I prepared an interview guide (see Appendix 4), which would be a “reminder of core aspects of the research question to be asked about” (Darlington & Scott, 2002, p. 59). Indeed, I provided a semi-structured interview to focus on particular themes, it was neither strictly structured, nor completely non-directive. I was also open to changing the sequences of questions (Esposito, 2001; Hesse-Biber, 2007; Kvale, 2007). Using the idea from Hillary Graham (as cited in Reinhartz, 1992): “The use of semi-structured interviews has become the principal means by which feminists have sought to achieve the active involvement of their respondents in the construction of data about their lives” (p. 18).

I knew that interviewing would be a craft and I would be the research instrument. I was aware that the quality of knowledge produced in my research depends on my tasks, as well as my knowledge of the subject matter and my skills to interpret the meanings of what would be said and how it would be said (Kvale, 2007), as well as silences and what would not be said (Barbour, 2007). In addition, I was prepared for “meaning-oriented reply” (Kvale, 2007, p. 11) questions or other “probes” (Hesse-Biber, 2007, p. 126) as ways of getting the participants to continue with what they were talking about, to elaborate or to go further; that might provide important information (Hesse-Biber, 2007; Kvale, 2007).

## **Sampling**

The aim of qualitative research is to find the meanings that respondents attribute to their given social situation, so it is not to make generalizations. Therefore, the optimum number of participants for interview may vary and it depends on questions, economic resources, and the participants as the resources available to the researcher (Darlington & Scott, 2002; Hesse-Biber, 2007; Kvale, 2007). It is suggested to interview as many participants as necessary to find the answers, neither too small to hardly find differences among groups, nor too large to hardly analyze the results; this tends to be near  $15 \pm 10$  participants (Kvale, 2007). The sampling was planned to be purposeful in order to maximize the depth of the data to address the research question (Hesse-Biber, 2007). Thus, the eligibility criteria for my study included being the first generation of Iranian immigrant women; being over the age of 18; living in Ottawa/Gatineau; and being willing to be interviewed. Ottawa/Gatineau provided the geographic base for my research.

## **Ethical Considerations**

I read the Tri-Council Policy Statement as it sets out the ethical guidelines for conducting research with humans. The Policy has three core principles: respect for persons, concern for welfare, and justice (2010). I knew that ethical issues were a priority when people were being interviewed and I had two areas of prime concern: confidentiality, and the potential consequences of the interview process (Fontana & Frey, 2003; Whiting, 2008). I was aware that ethical issues go through the entire interview inquiry, from the beginning to dissemination of the final report, and I was also aware that the interview process is a moral enterprise (Kvale, 2007). Therefore, I maintained “clear and unwavering respect for the

dignity and worth of individuals” (Satcher, 1996, p. 1707). As a result, I prepared a consent form and applied for ethics approval. These ethical issues had four benefits: reduce the risk of unanticipated harm and exploitation, protect the respondent’s information, and inform her about the nature of study (DiCicco-Bloom & Crabtree, 2006).

## **Interviewing**

Once receiving the University of Ottawa Research Ethics Board (REB) approval (see Appendix 5), I adopted multiple strategies for the recruitment of the participants. First, I had planned to recruit the participants just through announcements (see Appendix 6) in a local Iranian store and magazine, as well as at Iranian gatherings. Later, when I was not able to generate an adequate number of participants to interview using this technique alone, I turned to the snowball technique in order to recruit additional participants. In advertisements, I invited Iranian women with the inclusion criteria to contact me if they wished to participate. Following their contacts, I explained the study and answered any questions when or if they arose. I also explained that the place and time of interview would be chosen by the participants.

My thesis involved interviews with twelve Iranian immigrant women. Interviews were conducted from November 2013 to January 2014 and, based on respondent preferences, most took place in coffee shops—with the exception of three that were conducted in participants’ homes.

Before starting the interview, I talked about the purpose of the study and approximate length of the interview. I also explained the process and the consent form (see Appendix

7)—which was available in both Farsi and English—that described my commitment to confidentiality, anonymity, and the conservation of data. In addition, I assured participants that there would be an opportunity to ask me questions and they could decline to answer any questions.

I asked the participants to read the consent form and if they needed any clarification, it would be provided. Then I obtained their informed consent. The informed consent involved obtaining the respondents' voluntary participation. All participants was reassured that they would have the option to withdraw from the research at any time and if they chose to do so, all data gathered until the time of withdrawal would be kept or destroyed based on the participants' decision. I also emphasized that during the interview, the participants would have the right to take a break, change topics or stop the interview.

For the interest of anonymity, confidentiality, and safety, I have changed some details, selected a false name for the participants and have used it on all material and public presentations, written or oral, so that the participants are not personally recognized in any public presentation of research. All data collected (recordings, transcripts, notes, hard copy, and electronic data), have been kept in a secure manner and I have put them in a file that only I have had access to them. Before starting the interview, I asked participants to fill out a brief personal data questionnaire (see Appendix 8).

I had planned to audiotape the interviewees and take notes, so I obtained the participants' permission to do it, as they all agreed. I used two high quality audio-recorders in order not to lose any part of the interviews, and also provided extra batteries. Based on

participants' preferences, I conducted all interviews in Persian (Farsi); with one exception, which was conducted in English.

As part of the processes of establishing rapport and gaining trust, which is essential to the success of an interview (DiCicco-Bloom & Crabtree, 2006; Fontana & Frey, 2003; Hesse-Biber, 2007), I began the interview with general conversation. It also provided a more relaxed atmosphere. Then, I again thanked the participant for her participation, checked the recorders, and turned them on. My first question was an open-ended question, which reflected the nature of the research (DiCicco-Bloom & Crabtree, 2006; Kvale, 2007). It is suggested that descriptive questions which use “what” and “how”, encourage interviewees to talk about their experiences (Darlington & Scott, 2002). I was aware that the problems of an interview inquiry might tend to surface in analysis stage; therefore, I tried to solve them in the early stages by improving the quality of my interviews through clarification and asking control questions (Kvale, 2007).

As a result, if necessary, I repeated the question and gave time to participants to think. Moreover, with repeating the words used by interviewee, I tried to clarify without leading the interviewee. I also asked unplanned follow-up questions (DiCicco-Bloom & Crabtree, 2006) to show the respondents that I was listening to the issues that matter to them and/or encouraging them to talk more if the issue was relevant to my research, without pushing my own agenda to the conversation (Hesse-Biber, 2007). If the respondent's statements were ambiguous, I would try to clarify them—as much as possible—in order to obtain confirmation or disconfirmation of the interpretation of what she was saying (Kvale, 2007).

During interviews, I observed the bodily gestures, facial expressions, and visual cues and I also took brief notes in order to record expressions and feelings and completed them after interviewing because they would provide a richer access to the meanings for the later analysis of transcripts (Hesse-Biber, 2007, Kvale, 2007).

I finished the interviews by debriefing: first by asking the participants if they had any more to say before turning off the recorders (Kvale, 2007), and then by leaving time for some day-to-day conversation—“not grab the data and run” (Barbour, 2007, p. 92)—to show my interest in participants as a person not just as a research participant (Darlington & Scott, 2002). It was a common experience that the interviewees told me that they enjoyed talking freely and sometimes expressed that they obtained new insights about their life world, or brought up other topics or added to what they had said. As Taylor (2002) indicates, the research interview might be a site of healing. I had provided some relevant helpline contact numbers to build protective measures (Barbour, 2007). I also talked more about the purpose of my study, if the participants were interested (Kvale, 2007).

I anticipated that an interview would take approximately 60 to 90 minutes, but it took longer—some interviews extended more than two hours. I conducted all interviews in one session; however, I contacted two participants for a short follow-up session and they agreed to answer my questions by phone. Moreover, one woman who wanted to expand her ideas contacted me.

I had initially proposed to conduct focus groups in my research to supplement the information produced in the interviews, although as the result of unwillingness of the respondents to participate and discuss in a group this method was later abandoned and I

devoted my time to carrying out more interviews. The presence of distrust among Iranian immigrants is a recurring problem and it has been reported by Iranian researchers (Chaichian, 1997; Dastjerdi, 2007; Ghorashi, 2003; Parya Trillium Foundation, 2012), as well as non-Iranian researchers (Bailey, 2004; Muys, 2009). While some populations might be wary of participation for fear of exploitation, misuse, and distortion of data, others may be guarded as a result of their unique circumstances related to the immigration experience (Umaña-Taylor & Bámaca, 2004).

It is prevalent among Iranians to be suspicious of any researcher who tries to gather information about their private lives and they are reluctant to provide this information (Chaichian, 1997). Hesitation to participate in research might be due to the sense of distrust and insecurity as a result of the political climate where Iranian immigrants came from (Parya Trillium Foundation, 2012). Moreover, some of the participants of my study were reluctant to talk about their household income and considered this very personal; therefore, they left this part of personal questionnaire blank.

### **Transcribing**

Transcribing means preparing the interview material for analysis most often by a transcription from oral speech to written text: from oral discourse to written discourse (Kvale, 2007). I transcribed all the recordings verbatim very soon after the interview session, except one where I took extensive notes. I listened to the recordings several times in order to increase the accuracy of my transcription in an effort to not to lose a single word. While recording of the interviews involves losing the body language, transcribing involves the second abstraction: the loss of tone, intonations, and the breathing (Kvale, 2007). However, I

tried my best to record the body gestures and emotions at the time of interviews, as well as tone of the voice in the course of transcribing, which helped me for the later analysis of the meaning of what was said. I found that the best way to ensure that I accurately portrayed the participants' accounts was to transcribe the recording at the earliest possible opportunity after the interview and to use brackets to record pause, emphasize, and emotions.

## **Analyzing**

“Data analysis is the process of reducing large amounts of collected data to make sense of them” (Kawulich, 2004, P. 97). While there are multiple ways of analyzing qualitative data, there is no prescribed way or magical tool to address the process and uncover the treasures of meaning buried under an increasing mountain of transcripts (Kawulich, 2004; Kvale, 2007). The chosen techniques of analysis stem from a combination of factors including the theoretical foundation of the study, the research questions being asked, and the appropriateness of the technique (Kawulich, 2004; Kvale, 2007).

Data analysis proceeded simultaneously with the data collection, by facilitating the discussion and generating rich data, using observational notes, transcribing, and reading the transcripts several times (Kvale, 2007; Rabiee, 2004). During the interviews, clarification and interpretation of the meaning of what was said allowed me to have “an ongoing ‘on-the-line interpretation’ with the possibility of an ‘on-the-spot’ confirmation or disconfirmation of the interviewer’s interpretations. The result can then be a ‘self-correcting’ interview” (Kvale, 2007, p. 102).

I also immersed myself in the data (Kawulich, 2004) by reading and re-reading the transcripts several times to establish a close familiarity with the data and then summarized each interview (Kvale, 2007). Afterwards, I looked for the themes and patterns (Kawulich, 2004) by writing memos as short phrases, concepts or ideas and developing categories. Ryan and Bernard (2003) explore multiple ways to identify themes: repetitions, metaphors and analogies, transitions, similarities and differences, and theory-related material.

The next stage included indexing, highlighting and sorting out quotes, and making comparisons. The last step began by charting and re-arranging the quotes in order to develop appropriate thematic content (Rabiee, 2004). I abstracted and named the themes and looked for the connections between them to group them together in a meaningful way (Fade, 2004). Moreover, as Karp underscores the significance of seeking “negative cases” that do not fit with the research, which might be the most informative (as cited in Hesse-Biber, 2007, p. 145), I paid attention to find these cases.

### **Verifying**

Verification is defined as “the process of checking, confirming, making sure, and being certain. ... [It] refers to the mechanisms used during the process of research to incrementally contribute to ensuring reliability and validity and, thus, the rigor of a study” (Morse, Barrett, Mayan, Olson, & Spiers, 2002, p. 17). While reliability indicates how consistent the research findings are, validity refers to the issue of whether an interview inquiry investigates what purports to be investigated (Hammersley, 2008; Kvale, 2007). Most importantly, validation permeates the entire study process and rests on the quality of the researcher throughout the research process, continually checking, questioning, and theorizing the findings (Kvale,

2007; Morse et al., 2002). Guba and Lincoln propose that the criteria in the qualitative paradigm to ensure "trustworthiness" are credibility, transferability, dependability, and confirmability (1982, p. 246).

I used several strategies for establishing the rigor or trustworthiness as a desired goal of my study; as Morse et al. point out, "Without rigor, research is worthless, becomes fiction, and loses its utility" (2008, p. 14). In qualitative research, getting the opinion of people who participate in the study is a useful tool. Taking data and interpretations back to the interviewees and giving their feedback, so called "member checks" (Guba & Lincoln, 1982, p. 247) or "member validation" (Kvale, 2007) is a validity procedure (Creswell & Miller, 2000; Curry et al., 2009). According to Lincoln and Guba, this is "the most crucial technique for establishing credibility" (as cited in Creswell & Miller, 2000, p. 127). My original plan was to verify each transcript with the participants; however as they were too busy, the transcripts were too long, and some of the interviewees did not show interest in it, in consultation with my supervisor, I decided to contact whomever was interested and to share my findings. Later I received and integrated their feedback and suggestions.

The other way is using "audit trail," which refers to documenting details of the technique, as well as research and data analysis processes (Guba & Lincoln, 1982, p. 248)—as I described in extensive detail. Another way for obtaining validity in a study is to provide enough information about a context or "thick description" (Guba & Lincoln, 1982). For this purpose, narrative excerpts are used throughout the next chapter to enhance transferability (Kvale, 2007) of the findings, which is one aspect of trustworthiness (Guba & Lincoln, 1982, p. 248). Finally, I applied other recommendations, which included methodological coherence by ensuring congruence between my research question and the components of the method;

sampling appropriateness by recruiting participants who had knowledge of the research topic—as participants were experts on their lives (Morse et al., 2002); collecting and analyzing data concurrently—as mentioned before; and theoretical thinking by constantly checking and rechecking—as I did (Kvale, 2007; Morse et al., 2002).

### **Reflexivity**

Reflexivity is my last validity procedure, “whereby researchers report on personal beliefs, values, and biases that may shape their inquiry” (Creswell & Miller, 2000, p. 127). In this vein, it is an attempt “to uncover one's underlying epistemological assumptions, reasons for formulating the study in a particular way, and implicit assumptions, biases, or prejudices about the context or problem” (Guba & Lincoln, 1982, p. 248). The interview is considered a “negotiated text,” a method which is influenced by the personal characteristics; a site where power, gender, race, class, ethnicity intersect (Denzin & Lincoln, 2003b)—as well as sexual orientation, age, and dis/ability.

Reflexivity is an important tool that allows researchers to be aware of their relationship to those whom they interviewed, to understand their roles in terms of power and authority over the interview situation (Barbour, 2007; Beckman, 2014; Denzin & Lincoln, 2003b; Hesse-Biber, 2007). Feminist researchers have to practice it on all accounts during the research process (Hesse-Biber, 2007). It is an integral part of conducting research, an inevitable aspect of language use, a critical consciousness of the discourse, a turning language back on oneself, and a controlling judgmental gaze (Davies et al., 2004). While self-reflection is important in order to decrease the power relation, being too personal may be

seductive and can encourage participants to disclose the more intimate information they may later regret (Kvale, 2007).

Reflexivity is a journey that began prior to my entering the field by taking a critical look inward and accepting that I, the researcher, am also a product of society's institutions and structures and my social position influences the way I observe and the questions I ask (Hesse-Biber, 2007). I have attempted to talk about my beliefs and reasons for undertaking this research in the first chapter to show I recognize my assumptions, which can intervene in the research. I have wanted to explain that I know my feelings and background construct knowledge (Hesse-Biber, 2007). The notion of reflexivity becomes important once again when I want to discuss my similarities and differences with the participants regarding my insider/outsider status.

## **Insider/Outsider**

According to Gair, "The notion of insider/outsider status is understood to mean the degree to which a researcher is located either within or outside a group being researched" (2012, p. 137). It is argued that there are costs and advantages to be weighed regarding the insider/outsider status. While there is considerable benefit to an insider role as it can afford access into a group and provides a level of trust and rapport with participants that makes the initial process much easier, there are some risks and drawbacks (Dwyer & Buckle, 2009; Hesse-Biber, 2007; Paechter, 2013). For instance, it is possible that the interviewees due to similarity fail to explain their experiences fully (Dwyer & Buckle, 2009; Hesse-Biber, 2007), or the interviewer as a member of group has difficulty separating personal experiences, which later shape the interview (Dwyer & Buckle, 2009). Moreover, being an insider does

not guarantee a more reliable and valid interview (Hesse-Biber, 2007), nor does being an outsider create immunity for unbiased research (Dwyer & Buckle, 2009).

I thought that informing the participants about my background as a physician—as I informed them through advertisement and at the beginning of the interview—might be an advantage to afford access and encourage Iranian women to take part in the study, as well as building trust (Seymour, Bellamy, Gott, Ahmedzai, & Clark, 2002). I also thought that my medical training and experiences helped me in setting a comfortable environment for the participants. I was aware that it could also increase the possibility of authority and power imbalances between me and the participants, and might build up “textbook” responses (Edwards, Matthews, Pill, & Bloor, 1998, p. 299).

During interviews, some participants told me, “you know it better than me as you are a physician” and I always answered, – as my feminist perspective provided an awareness of the power dynamics of interview – “I want to understand what you think and know the meaning from your point of view” and “I am here to learn from you and you have the knowledge that I do not have,” to reduce my power as well as to empower them as my co-researchers and co-constructors of knowledge—which is a feminist goal. Furthermore, I was aware that identifying myself as a health care professional might bring another problem as participants might seek advice from me, which can create ethical consideration (Barbour, 2007).

I also realized that while the interviewer generally has a “monopoly of interpretation” over the participant’s statements, some interviewees might start to question the interviewer about the subject (Kvale, 2007, p. 9). Some participants turned back the questions to me and

asked my opinion. It was a difficult decision whether my answers might lead to important knowledge or influence their forthcoming answers. Once in a while, depending on the questions, in order not to lead the answers, I took notes on the questions and respectfully—as my feminist perspective, my culture, and ethical consideration taught me to be respectful—told them that I would answer their questions at the end of the interview, as I did. However, I responded to any questions about me when or if they arose. I tried to avoid “getting trapped” by postponing my opinion by saying “you’re the expert” or “it’s your opinion that’s important” (Fontana, & Frey, 2003, p. 86).

Holding my own national identity, being a woman, and an immigrant did not denote complete sameness within the group, particularly considering the fact that Iranians have diverse ethnic, geographic, economic, religious, and political background and social hierarchies exist within them (Dossa, 2004). Moreover, an insider/outsider status is fluid and might change in the course of an interview (Hesse-Biber, 2007). I had felt that I was an insider until one of the participants claimed that she was different from me because I did not come to Canada as a refugee.

In short, while I considered myself as an insider, the fact remained that, to some I was an outsider or expert, therefore, I was aware that, who I am, did affect how respondents perceived and interacted with me. On the other hand, how participants reacted to me was an important issue that struck me during and even after the interviews. While I was warmly greeted by my interviewees, sometimes I felt that formality of the interviews—particularly as a result of audio-recording—did not allow the respondents to properly answer my questions and once the interviews were formally over or when they asked me to turn the recorder off, they talked more freely. Moreover, for my part, sometimes I experienced embarrassment

when asking or following up very personal issues such as topics pertaining to sexuality and family problems.

Furthermore, considering my theoretical framework, intersectionality, which attends to group differences and similarities and insists on examining the dynamics of sameness and difference, “I found myself caught in the peripatetic liminality of being unsure of how to position myself” (Oriola & Haggerty, 2012, p. 541). I found that the dichotomy of insider versus outsider was overly simplistic (Dwyer & Buckle, 2009; Paechter, 2013). As the question of who I am is neither static nor unitary (Doucet & Mauthner, 2008), I locate myself in an “in-between position” (Ghorashi, 2005, p. 363). The hyphen bridges and brings together insider and outsider status. It “acts as a third space, a space between”; positioning me as being “with” my participants (Dwyer & Buckle, 2009, p. 60). Moreover as a researcher, I cannot also fully occupy one or the other. The women’s voices are real to me, meanwhile I am the interpreter; a human being who carries the experiences, words, and transcripts, whose persona does thoroughly impact on the research process. The hyphen becomes a “dwelling place” but a “tensioned space” for me with all costs and benefits, “a dialectical approach allows the preservation of the complexity of similarities and differences” (Dwyer & Buckle, 2009, p. 60) as my theoretical framework insists on examining dynamics of difference and sameness.

## **Chapter Five: Findings**

I begin this chapter by providing some demographic data of the participants, followed by the respondents' understandings of contextual meaning of health/wellbeing. Next, I continue by how the participants felt about their health/wellbeing before and after the immigration, and finally I go through the thematic and sub-thematic categories of factors that influenced the participants' health/wellbeing.

### **Demography of the Participants**

All the participants came to Canada during their adulthood. Nine of the participants have been living in Ottawa/Gatineau since they came to Canada; three lived in other cities for a few months to less than two years before moving to the Ottawa/Gatineau area. Three were living in Gatineau and the other nine were Ottawa residents. The length of their residence in Canada varied from one year to 25 years. I grouped the participants in three categories—where I could find a clear cut-off point—as: four recent (<4 years), four intermediate (5-14 years), and four long-term residents (>20 years).

The majority of women were middle-aged, six of them were between the ages of 50 and 60, four were in their sixties and the two others were under the age of 40. Three came to be reunited with their families on Canadian soil; three came as refugees; and four entered the country as economic immigrants. Two respondents entered Canada as temporary residents—one was an international student and the other was a wife whose husband was employed in Canada—both would later become permanent residents as an economic immigrant and as a refugee, respectively.

At the time of the interviews, three were living as divorcees and five were married—both married and divorced women had children except one. Of the remaining informants, three were single and one was living with her common-law partner and their children. With a single exception, all had been employed in Iran (eight in full-time positions); eight participants were currently engaged in employment in Canada (three in full-time positions). The four remaining respondents did not report paid employment. All participants excluding one had some college/university degree or obtained a graduate degree (see Appendix 9, all the names and some identifiable markers have been changed to secure anonymity and confidentiality).

### **Iranian Immigrant Women's Perceptions of Health and Wellbeing**

I began the interviews with a very broad opening statement, “What does health/wellbeing mean to you?” to capture a definition of health/wellbeing and then went through the other questions. Broadly speaking, the participants defined health in a holistic sense, incorporating physical, mental, and social aspects, by highlighting the importance of mental wellbeing to one's overall health. Participants tended to describe health in terms of living in peace without stress and concern, living happily, the ability to think and make a decision, a life without permanent pain, being able to function, and living in a society that allows its citizens to live healthy and stable lives. This echoes the definition of World Health Organization (1948) that defines health as not solely the absence of disease but as a state of physical, mental, and social wellbeing.

This finding is inconsistent with the results of an earlier study (Meadows, Thurston, & Melton, 2001) in which the physical aspects appeared to take precedence for the research

participants who were mid-life women emigrating from different countries to Canada, but is consistent with the findings of two other studies (Dean & Wilson, 2010; Elliott & Gillie, 1998) that found that their immigrant informants espoused a definition of health that encompassed both physical and mental wellbeing. It is also congruent with the findings of researchers in Sweden where Iranian immigrant women viewed mental health as a crucial complement to physical health and wellbeing (Akhavan et al., 2007). Similar findings were observed in a study conducted by Weerasinghe and Mitchell (2007) wherein participants—who emigrated from different countries embraced a complex and holistic definition of health that incorporated physical, mental, and social components.

This holistic approach to health and wellbeing was reflected in the responses of the women with whom I spoke. For Mina, a recent immigrant in her fifties; “Health is everything.” Arezoo, who came to Canada as a refugee, echoed these thoughts: “When the body hurts, the soul is damaged and when the soul hurts, the body is damaged.” Touran, a long-term resident concurred, “particularly [when you are talking about] immigration, [the health of] soul and psyche makes an important part of health”. Mahtab, another long-term resident, elaborated; “for me, a healthy person is a happy person”. Bahar, a mid-term resident, also mentioned wellbeing meant having “content and happiness” in life. Being happy, as an indicator of good health, is similar to the findings of Jafari et al. (2010) whose research conducted in Vancouver stated that happiness was one of the signs of good mental health among Iranian immigrants.

Bahar further noted that health “changes over time.” This “plasticity of conceptions of health” (Idler, Hudson, & Leventhal, 1999, p. 474) was echoed in Roya’s—a woman with a physical disability—definition of health; she stated: “because my problem is pain, [for me

right now health means] having function...ability to do your daily activities”. As other researchers (Idler et al., 1999) discuss, the broad and more inclusive definitions of what health is, allowed the participants to take more factors into account when later examining their health/wellbeing. More importantly, while some participants described a set of physical health problems such as high cholesterol or joint pains, they did not report their health as poor.

To conclude, the participants defined health as a multidimensional construct comprising physical, social, and mental wellbeing and the outcome of their interactions. As Parisa, an Iranian woman in her early sixties, mentioned:

Health means social, mental, and physical health. When all three are together, a person is healthy. If someone just walks and eats, does not mean that s/he is healthy. ... Mental health means you can understand and think and social health [means] that you live in a healthy society and you are able to live healthy in that society.... [It means] better safety, [when] one feels comfortable and secure.

## **Self-reported Health: A Useful Toolbox**

I used self-assessed health as a measure of health status before and after immigration. This indicator evaluates individuals’ perception of their overall health (Human Resources and Skills Development Canada, 2014) and is ascertained with the question about perceived health, “how do you describe your general health?” (Sundquist, 1995, p. 129). It is not a direct measure (Newbold, 2009; Newbold & Danforth, 2003); however, a plethora of scientific studies suggest that self-reported health is a good proxy for health status (De Maio & Kemp, 2010; Franzini & Fernandez-Esquer, 2004; Idler & Benyamini, 1997; Idler et al.,

1999; Maddox & Douglass, 1973; Newbold, 2009; Newbold & Danforth, 2003; Shields & Shooshtari, 2001; Wu & Schimmele, 2005b). Self-assessed health status is one of the important determinants of quality of life (Wu & Schimmele, 2005b), a powerful predictor of subsequent events such as mortality (Idler & Benyamini, 1997), disability (Kennedy, Kawachi, Glass, & Prothrow-Stith, 1998), chronic conditions (Hennessy, Moriarty, Zack, Scherr, & Brackbill, 1994), and a helpful tool for inequality researchers (De Maio & Kemp, 2010). Self-assessed health status is widely used across the world, in Canadian studies (De Maio & Kemp, 2010; Dunn & Dyck, 2000; Kim et al., 2013; Kobayashi, Prus, & Lin, 2008; Laroche, 2000; Newbold, 2005a, 2005b, 2009; Newbold & Danforth, 2003; Newbold & Filice, 2006; Ng et al., 2005; Veenstra, 2009, 2011; Wu & Schimmele, 2005b); as well as in European and American research (Franzini & Fernandez-Esquer, 2004; Sundquist, 1995; Van Doorslaer et al., 1997).

While self-assessed health uses respondents' own perception of their health, it does not depend on a medical conceptualization of health (Van Doorslaer et al., 1997). In fact, by using self-reported health, respondents think of both the body and mind, a wide spectrum of factors, their current health, and trajectories of improvements and declines (Shields & Shooshtari, 2001). It is common to use five-point Likert scale from excellent to poor (Franzini & Fernandez-Esquer, 2004) and then later dichotomize it (Blakely, Lochner, & Kawachi, 2002; Kobayash et al., 2008; Siddiqi & Nguyen, 2010); however, I did not ask participants to strictly use this scale to rate their health.

## **Impact of Immigration on Health and Wellbeing**

I invited participants to describe their overall health/wellbeing before and after moving to Canada; later, they were asked whether their health/wellbeing had changed since immigration. The majority of participants pointed out that they had been in good health before moving to Canada, except two, Touran; a long-term refugee resident, and Bahar; a mid-term economic class resident.

They explained:

[When I was in Iran,] I had suffered from severe colitis ... [but here in Canada] my colitis was gone, because I didn't have the stresses that I had had there. (Touran)

[Before coming to Canada, my health] was a mess. ...I lost both of my parents [in an accident], so it affected me both at the physical and psychological levels. ...I wasn't really healthy... I was so psychologically depressed. (Bahar)

With respect to health change after immigration, informants' responses were mixed. Four of the participants answered that their health/wellbeing had stayed the same—one of them stated her health had primarily been the same, but she experienced a minor trend towards decline. Four participants indicated that their health/wellbeing had deteriorated, and four stated that their health/wellbeing had improved—three of these respondents mentioned that their health/wellbeing had been strongly boosted (see Appendix 10).

Roz, a long-term immigrant in her fifties, expressed:

I think immigration has not influenced my health. I am among the cases since I came here, I have not been under too much pressure.

Parisa explained:

I had better health before immigration.... I didn't have specific mental or physical problems. I lived [in Iran] better than here...definitely [with emphasis] [immigration] has affected my health [negatively].

The poignancy of negative impact of immigration on the health and wellbeing was also highlighted by Arezoo:

Immigration ruined my life...something collapsed in my life and I don't know how to say it ... it [immigration] made my life empty.

Touran, who ran away from Iran to escape death, described:

Immigration has great positive influence on my health. ... I didn't feel secure in that society [Iran], my life was threatened, [so] for me it is the best.

Bahar indicated:

Immigration absolutely has been great for me, because I'm a lesbian. So, in Iran I was nobody. ... [In Canada] I can be who I am. So it is the biggest gift that immigration has given me.

Being in a good health at the time of arrival, as the majority of the participants indicated, supports the previous research (see literature review) on the healthy immigrant effect. However, while a growing body of scientific study (see literature review) reveals that immigrants' health advantage dissipates after settlement in Canada, half of the participants of this study mentioned their health had not deteriorated after immigration, it had remained

same or had even been enhanced. In addition, the health of two other respondents who had not been in a good health before coming, was also improved. There was not a strong relationship between the length of residency in Canada or immigration status and change of the health status after immigration. Recent immigrants reported an improvement in health just as the mid-term and long-term immigrants did, and refugees reported a worsening of health just as economic or family class immigrants did; although their reasons for doing completely differed.

This finding is consistent with the results of a recent study conducted by Dean & Wilson (2010) in the Greater Toronto Area with adult immigrants—six out of 23 were European, ten were women, and near half were recent immigrants—that show the majority of the respondents believed their health status remained stable and even improved after settlement in Canada. There are also several explanations for this result. As Ng and the LHAD research team (2011), by analysing the age standardized mortality rates (ASMRs) for immigrants in Canada suggest, with regard to losing of the healthy immigrant effect; factors such as world region of origin, place of residence, and period of immigration might result in differences between immigrant subgroups. Moreover, age at immigration and pre-migration socio-economic conditions might influence the loss of immigrants' health advantage overtime. Finally, even when, some immigrant subgroups lose this advantage after settling, they are still healthier than Canadian-born population. Therefore, maintaining or improving the health status of participants might be a result of pre-migration experiences and socio-economic conditions, as well as their age at the time of arrival and living in a mid-sized city.

## **Iranian Women's Perceptions of Determinants of Health**

As the goal of my research was to examine how Iranian immigrant women perceive their determinants of health, I needed to explore the reasons for reported changes or conversely the stability of their health/wellbeing. Therefore, I first asked them which factors they thought had most affected their health/wellbeing without probing into particular details, and how and why these issues had impacted on their health. I also aimed to explore the social determinants of health as suggested by the Public Health Agency of Canada (see literature review); particularly, the determinants that might change after immigration, as well as social indicators and other factors that I found important when I was studying immigrant health, such as language proficiency.

I organized the participants' perceived determinants of health status and the qualitative interpretations of interviews into the thematic categories (see Table 1). While there were some commonalities shared amongst participants identified as Iranian immigrant women, the heterogeneity of the participants created a complex picture.

Table 1: Thematic Analysis

| Themes                  |                                             |
|-------------------------|---------------------------------------------|
| Gender                  | Age/Ageism                                  |
| Language Proficiency    | Immigration Experiences/ Stage of Migration |
| Education               | Sexual Orientation                          |
| Employment              | Race/Racism                                 |
| Income                  | Weather                                     |
| Disability              | Health Care Services                        |
| Social Support Networks | Healthy Behaviours/ Coping Strategies       |

In the next sections I go through each theme and then follow it by a discussion.

## **Gender: A Fundamental Determinant**

Regarding gender two subthemes were revealed. First, for all participants with children—both married and divorced—the family-centeredness of their experiences was a significant factor mediating all aspects of their health, where the future and wellbeing of the children took on a particular significance in their lives. Moreover, caretaking of family members with disability or illness was the responsibility of women as mothers, wives, or grandmothers. Second, the gender-based socioeconomic restrictions and/or hostility they faced in public space in their home country was another factor mentioned by informants. I termed these two subthemes, family as a unit and hostile public space, respectively.

### ***Family as a Unit: My Responsibilities Are Exhaustive but Fulfilling***

All married and divorced women who had children before migration actively participated in the labour market in Iran, meanwhile taking care of their children. As the result, migration did not change their traditional roles in the family and the normative constructions of gender and of women's responsibility for children caretaking were re-inscribed through migration. However, the lack of a female-centered network—which was a significant source of help—affected many of them after coming to Canada.

Broadly speaking, mothers bore the bulk of caring and household responsibilities that prohibited those in particular who had young children, from education, employment, and participation in the language classes, and further structured women's working conditions. These responsibilities were also the major components that led to deterioration of some participants' health and, ultimately, caused lifelong disability for one of the women. All of the above-mentioned determinants must be seen within the context of gender roles; however,

their impacts were so significant that they affected the further socioeconomic status and health of women. Moreover, these factors intertwined by other determinants; consequently, I prefer to discuss each as a separate theme later.

Some respondents who had dual responsibilities—raising children and taking care of housework, as well as engaging in the labour market—were under tremendous pressure. For Mahtab who was forced to accept her stressful job following economic hardship as a result of divorce, work-life conflict was so serious that she felt guilty about not spending time with her family—before her cancer diagnosis resulted in several months’ absence from the work. She described:

[As a result of shifting job] when I returned home, they [my children] had slept. When they woke up in the morning, I was sleeping because I was tired. I had a guilty feeling. [When they arrived from school] I had not been at home to warm food or to chat with them. As a mother, I always felt guilty and for many times [after the cancer diagnosis] I told, “Thanks universe for getting me cancer!”...

Not all mothers experienced the same level of role overload and its level was associated with their children’s age. Moreover, in order to maintain the balance between work and life, some participants stayed at home, found a job that was compatible with their family responsibilities, or changed their jobs. Furthermore, the role of social support networks in the host country was not negligible—for instance, having a supportive husband versus being a single mother.

Three women were also responsible for taking care of their relatives living with disabilities or illnesses. Sahar described:

[Before coming to Canada] my husband had depression but it became worse [after several years living in Canada]. Since five years ago, he has not been able to work. I tried to carry all [responsibilities] alone, but I would find that I could not carry this heavy burden anymore. ... I was looking for help [disability pension] and I was told that I was ineligible because I had income. ... But my income is really nothing. When nobody helps you, it affects your health. ... Some [people] told me to get divorce. But I don't want. Some [people] advised me to lie. I know some people abuse the system. But I don't want to lie. It hurts me because I told the truth and nobody helped me. It is not fair. ...I have never talked about my hardship with my children. I've always tried to give them energy and encourage them to be happy. I am under great pressure but I don't want they [my children] know.

Sahar had broken under all tremendous pressures yet she still tried to maintain her family as a happy unit. She explicitly and implicitly made links between her individual experiences and her larger family, as well as social structures.

Touran, who switched her job from full-time to part-time in order to take care of her grandchildren, expressed:

My granddaughter was diagnosed with cancer. ... I had to sit and see her suffering. Her pain really hurt me but I had to be silent and not to show my distress. I had to help her, her mother, and her father.

I have to underscore that participants considered home as a site of work. For instance, Roya indicated, "I think housework is a form of job" and by this account, she recognized women's work in the private sphere and made it visible. Jawaher expressed:

I've looked at housework from another point of view. For example, I like to cook, so it's a fun for me and I enjoy.

Importantly, some made a positive link between health/wellbeing and their gender. In the manner that Roz survived the blues of her first years of arrival mostly because of the happiness she felt at the birth of her children. Another respondent, Touran, indicated that as a mother she had made a significant contribution to society:

I am proud that I'm a woman. ... I've brought my children well. They are successful and this brings happiness to my life.

This point was also echoed in Roz's voice:

I stayed a few years at home to take care of my children. The first beginning years of a child's life are very important. I think it is one of the reasons that I didn't have any problem with my children during their teen years. ... I look at it as an investment. I am so happy when I see my children are mentally healthy.

## ***Discussion***

As the above-mentioned narratives indicate, the participants perform a disproportionate amount of domestic labour, child-rearing responsibilities, and caretaking of ill/disabled family relatives. Noticeably, the centrality of caregiving was incorporated as an essential component in their lives. Cross-culturally, women are too often assumed to take care of children because they “naturally know how to do the work” (Armstrong, 2004, p. 337); therefore, they are presumed to provide the “natural” responsibilities and considered “the most appropriate caregivers for children,” as well as people with illnesses and disabilities (Spitzer, 2005, p. S80). Therefore, following other researchers (Duxbury & Higgins, 2001; Vissandjée, Kantiébo, Levine, & N'Dejuru, 2003), I argue that the existing power relations in society that tend to perpetuate natural responsibilities of women and judge women's merit

by their performance of family roles, might impel women to internalize society's surveillance and to consider that enactment of caregiving responsibilities were fulfilling, which mirror another study's (Spitzer, Neufeld, Harrison, Hughes, & Stewart, 2003) findings that has examined the experiences of Chinese and South Asian women caring for a disabled or an ill relative.

Mothers reworked their priorities around their children and families' need and believed that one of their most appreciable responsibilities were to raise children as happy, successful, and healthy citizens. Building on the work of Spitzer et al. (2003), I argue that, while these activities might be acknowledged as both constraining and exhausting, they may not be considered as either oppressive or burdensome. However, lack of kin to rely on and economic hardship forced some respondents—as the narratives illustrated—to participate in the workforce, further restricting their time to fulfill caregiving and to conduct household tasks which was a source of stress. Additionally, low-wage employment and poverty might not allow some participants to purchase domestic services to ease their responsibilities.

Women might feel that caregiving was “a rewarding activity,” (Spitzer, 2005, p. S81) “a mission” that they “had to undertake” (Dossa, 2004, p. 154); however—considering the fact that some deprived from governmental support—“[a]side from the issue of reward, we may state that the person is actually punished” (Dossa, 2004, p. 155). Importantly, recent changes to the Canadian health care system—“crafted in terms of ‘home is best’” (Anderson, 2000, p. 223)—by relocating care from institutionalized care to home and community care significantly has increased such work by women. Furthermore, that care is not just emotional, but physical and social as well (Armstrong, 2007).

Importantly, women with multiple roles were more likely to be vulnerable to work-life conflict, which is a well-documented factor for a variety of negative health outcomes (see literature review). Consistent with other researchers' findings (Duxbury & Higgins, 2001), not all mothers experienced the same level of role overload and its level was associated with lifestyle stage—their children's age. While employed mothers were the most likely to report high role overload, some employed participants without dependent care responsibilities were in better health/wellbeing which is similar to the findings of another study conducted by Duxbury and Higgins (2003).

The above pieces also indicate that respondents perceived that social support was a significant factor for wellbeing of people with illnesses and disabilities and they, as mothers, wives, and grandmothers tried to provide emotional support for their family members. However, in general, the participants themselves did not have access to emotional support—as a result of the absence of live-in extended family relatives.

My final argument is that women were perfectly aware of the importance of their unpaid labour in the private sphere; meanwhile, we can consider some activities such as cooking as a way to exert control over the life (Moaveni, 2005) or a means for belonging through cultural rituals and symbols (Williams, 2011) and maintaining the identity and values that may explain why their wellbeing did not deteriorate.

### ***Hostile Public Space: “A Land of Paradoxes”***

The participants drew a connection between gender and sociopolitical changes after the Revolution and its effects on their health. Hostility found in public spaces in Iran was a commonly endorsed theme. Azadeh said:

[In Iran] when I wanted to go out, I always had stress. I was always in fear that they [morality guard] might arrest me for what I wore. I don't have this stress here.

While many participants lived in a family where their fathers, brothers, or husbands had never asked them to “what to wear,” intervention by members of the morality guard was felt utterly humiliating. It was also echoed in Bahar's voice:

Everything, everything [emphasis] is designed to insult women in Iran. So I [was] in constant fight and anger in Iran. Here I don't even feel it. I don't [want to] say that system is perfect for women [here] but compare to where I come from, it's heaven.

Bahar also built a link between social restrictions and healthy behaviour—restrictions for engaging in physical activity in a public setting:

[In Iran] I wanted to bike and I did not understand why I couldn't. Just simple pleasure in life that everyone has to have.

Azadeh described her work's experience in Iran:

I worked in a male-dominated field. I earned less than my male colleagues [for the same work]. ... One day I became sick, but I couldn't rest at home. Because I was afraid that they [my colleagues] thought I as a woman was weak. I stayed at work but my health condition got worse. ... There was no rules [in Iran], you had to prove yourself. You had to work harder than men to show your abilities... but I have better feeling here.

Jawaher depicted the following picture in order to show her dissatisfaction and exclusion from the workforce in her home country:

After the revolution I was forced to retire because I had talked about the realities of society and also because I had used makeup. ... My job was a social job and I enjoyed it but I was asked to be silent, so it was not my job anymore. I was also under pressure because of putting on makeup, and the everyday struggle made me nervous.

All who came Canada with their families mentioned that not only did their husbands not have the monopoly on decision making in the family, they themselves had decided on and initiated the relocating of their families. Moreover, some participants talked about changing the divorce laws that had disappointed them. Touran described:

[There] women don't have divorce right. You know, divorce is not a good thing everywhere. But it is a way to defend yourself.

## ***Discussion***

The majority of the respondents reported negative impacts on their health as the result of hostility they faced in public space in their home country as well as the constant struggles for gaining their rights denied by the state. These findings corroborate the ideas of Keddie (2003/2006)—as mentioned in Chapter One—who argues that ending the Family Protection Act which was aimed to curtail the women's equal rights in divorce and child custody, as well as obligatory dress code in 1980—first in all governmental and public offices—concerned and disappointed many women. Furthermore, the findings accord with Milani's observations that, in the early years after the Revolution, in order to “purify” public spaces, thousands of women lost their jobs or were coerced into early retirement (2011, p. 1). It is also important to note—as earlier mentioned—that following the Revolution, interestingly, female literacy has been significantly improved; however, men monopolized the highest

governmental offices, and women's education were less likely translated to high-paying and high-prestige jobs (Milani, 2011). As a result of such situations Milani termed Iran, "a land of paradoxes" where women can vote but:

[T]hey must observe an obligatory dress code. They can drive personal vehicles, even taxis and trucks and fire engines, but they cannot ride bicycles. They are forcibly separated from men into the back of buses but can be squashed in between perfect strangers in overcrowded jitney taxis. They have entered the world stage as Nobel Peace laureates, human rights activists, best-selling authors, prize-winning directors, and Oscar nominees, but they cannot enter governmental offices through the same doors as men. (p. XXIII)

It is important to indicate that Iran might be a unique country that has experienced different phases related to the veil—I use the term veil as an attire that covers the head not the face: traditional veiling, followed by politically motivated forceful unveiling in 1936 in order to modernize the country by adopting a Western model, and finally forced—again as a political agenda—re-veiling in the post-Revolutionary era (Dossa, 2004, Milani 1992, 2011). It is the state who always consider itself as "the owner or at least the shareholder in the bodies of its female citizens" (Milani, 2011, p. 11).

Therefore, in Iran for nearly a century, veiling has been a central issue in discourses of modernity and counter-modernity, and the female-body has been accounted as a battlefield by political movements in the name of either nationalism, modernity, progress, and freedom or tradition, security, and piety. While as a result of obligatory unveiling, women with veils—whose veils were the source of pride and respect—were harassed, bullied, humiliated, and denied the right to enter public streets; after the Revolution, this time the new regime by mandatory veiling has imposed its own ideal image of womanhood on the female bodies

(Milani, 1992, 2011). The most significant problem was always the tendency to not take an in-between position (Milani, 1992). Notably, veiling “is a context-bound institution” and must be understood by considering time, space, and, particularly, power (Milani, 2011, p. 10). Therefore, the veil in the Western world is not perceived “as a piece of attire with a complex trajectory,” rather it is bound to “the colonial narrative of the oppression of the Muslim women” (Dossa, 2004, p. 34).

In fact, in spite of multiple experiences of reversal—as the narratives indicated—the participants were politically active, they were the main decision makers for the immigration process, and worked in male-dominated fields, all of which contradict the stereotypes of immigrant women who are constructed as dependent and passive. Swanton’s study (2005) in Vancouver on Iranian immigrants revealed the similar results. Broadly speaking, the respondents’ efforts to defend their rights and, perhaps more importantly, make a distinction between their private lives and public spheres, revealed that they did not consider all Iranian women as victims and oppressed with all Iranian men as oppressors. However, the hostility of the public space and women’s constant struggles to gain the rights denied by the state in the home country were an important source of stress. On the other side, the participants constructed the host country as a peaceful state, consistent with informants of another study in Vancouver, “a place ‘free’ from the surveillance and regulation of the state” (Swanton, 2005) which was one of the reasons that enhanced the wellbeing of the majority of the respondents.

## **Language Proficiency: A Determining Factor**

Language mastery is one of the main factors affecting all participants. Coming from a linguistic background where English and French are neither the native languages nor widely used in daily communication, it is not surprising that all participants faced language barriers upon their arrival and for some of them has continued to be an obstacle or a source of stress. They believed that the inability to communicate in either of the official languages may create isolation, marginalization, stress, lower self-esteem, difficulty pursuing education or finding employment, and access to health services or remaining uninformed of existing services that all affect their health and wellbeing:

I always [in Iran] ...connected to people, I had powerful networking abilities [with laugh]...but [in Canada] it is very difficult, they think you don't understand but I understand [a bit angry] and it make me tired and I hurt.... I really lost my self-esteem for a while. (Mina)

[After more than 20 years living in Canada] still sometimes I want to say something, to express myself but I think nobody understand me. I have to repeat it again and again. I think that s/he thinks I am stupid, it hurts me ...it mentally upsets me. (Roz)

I feel that I was more comfortable and relax there [Iran], when I need a dentist. I went to a dentist [in Canada] but I did not understand what he said. ... I decided not to go to any doctor. (Azadeh)

[In university] I was being evaluated by the same criteria as native speakers. It was so tough. ... [Sometimes] I had to go to bed and just cry. (Bahar)

I have to improve my language, then look for a job in my field. (Arezoo)

For some of participants, language barriers act as a significant challenge limiting their ability to re-establish social ties. Some respondents argued that they tried to engage and develop friendships with people outside the Iranian community in order to improve their language proficiency and to feel a connection to society. However, they found it difficult to socialize with the mainstream culture even beyond language barriers.

You can't talk about something that you like because they [Canadians] don't know [they are not familiar with] your music [Iranian music] ... your film. It hurts me, I feel that I'm isolated. You know, there are different concepts.  
(Azadeh)

It was also echoed in Arezoo's words:

Always there is a wall. It is not because of the language [differences]. ... You want to be warmed, you want to be close, but there is an ice wall. You have to stay behind of it and freezing, you can't enter... it threatens my mental health.

However, it was not always the case, as Bahar noted:

... I've always ended up with Canadians. ... So it has accelerated my integration process ...and blended me in this culture.

Both married and divorced participants with children—with three exceptions who came here when their children were not too young—implied that they were not able to participate in the language classes or interrupted it because of their child care responsibilities, lack of a proper childcare, and the absence of a female-centred networks that they had nurtured in Iran. Roya, a long-term resident with disability, expressed:

I did not go to a language class. ...I had young children. ... I had no one to help me, to take care of my children. ... I learnt English at home [by myself], [when later I went to university], I faced with problems...it was too difficult. It was stressful. I sat long hours [for writing my papers], I forced myself. It harms my health.

Limited schedule of language classes, hard to time off work, and lack of affordable classes after being a Canadian citizen were also other barriers. Parisa explained:

After coming here, I had gone to language classes. [Later] I had to quit because I had to work. [An organization] helped me and gave me a teacher for two hours in a week. It was good but not enough...and when I became citizen they did not help any more.

## ***Discussion***

Language mastery was another element affecting all participants in some stage of their migration trajectory. Three key results from these voices have surfaced: first, poor linguistic sufficiency is associated with low self-esteem. Second, the failure to provide the proper language classes, further complicated by the paucity of affordable childcare, the limited schedule of courses, and cutback of funds, prevented Iranian immigrant women from social inclusion. Third, language ability exerted a major impact on education, employment, and social networks.

To begin, language barriers directly influenced respondents' health/wellbeing through creating stress and low self-esteem, which is consistent with the findings of a study (Pottie et al., 2008) revealing that poor official language skills among immigrant women were associated with poor self-reported health status. Moreover, like Siegrist & Marmot (2004), I maintain that self-esteem by strengthening feelings of self-worth, belonging, and approval

have a considerable influence on health and wellbeing. The findings are also congruent with the results of a recent study that indicate language proficiency and communication with the host society were some of the main concerns of Iranian immigrants, which affected their mental health (Jafari et al., 2010).

While my task as a researcher is “to identify the social pathogens that threaten health” (McGibbon, 2012b, p. 33); following other researchers (Morris, 2003; Spitzer, 2009; Stewart et al., 2006), I have to note that in addressing language insufficiency, it is critical to understand that funding restrictions stemming from the recent cutbacks—for providing child care, expanding the schedule of courses, affording free of charge classes after gaining citizenship—create significant barriers for accessing language classes for participants who were faced with time poverty and financial demands, as well as women who undertook child care responsibilities.

Language proficiency was as also a pivotal challenge intersecting with other factors: pursuing further education, finding employment, access to health services, and navigating existing services, as well as isolation and rebuilding new ties. Perhaps more importantly, the role of gender was neither separable nor trivial. I capture the agony of Iranian immigrant women as a result of problem in creating new friendships in a verse of a prominent Iranian poet, Mehdi Akhavan-Sales translated by Bashiri (n.d., para. 7),

Your greetings they'll ignore.

With their heads resting on their chests,

They seek warmth from their breasts,

None affords to lift a head to greet the guests.

...

Your extended friendly hand is refused,

Not because they are confused;

They rather keep their hands where they are warmed.

It is frightfully cold.

## **Education: A Heavy Burden on Her Shoulders**

All of my family members were educated. ...I have been the only one [who did not go to university] but [I] loved education. ... [At that time] universities were closed and then [my father] was executed...he was [in] the Shah's time a political prisoner [and a political activist after the Revolution who] was executed [by the regime after the Revolution]...I was not able to go to university [because of my family background, the government did not allow me] ...I lost my [father] and some of my best friends. I was under mental and social stress. I wanted to flee from that country and I decided to marry [in order] to come here. ...I liked to study here, but suddenly [I] was thrown to [another way]. I involved with marriage and my children [to bring them up] ... [sometimes] I blamed myself because I was not a determined person ... but [I think it is also related to other things] without financial support, without a family support [to take care of my children]...it [not continuing my education] hurts me. ... [As the result,] I am working in a place [where] I feel I am not fit with it. If I had education, I would have worked in a better place with less stress and I would have been happier...my job is stressful, it needs a lot of attention, physically and mentally ... a multitasking job ... with tight schedule ...I [also] have to care of everything at home, shopping, cooking, laundry... [I had been under] a lot of stress... [Lastly] my body paused. ... I think the most important cause of my cancer was stress. (Mahtab)

## ***Discussion***

The above narrative shows more than what appears on the surface. It brings to light two issues: first, launching the Cultural Revolution—about three years shutdown of universities in Iran with the aim to “de-westernize” them (Chaichian, 2012, p. 23)—which delayed, interrupted, and destroyed the educational livelihood of many Iranians; and second, the mass crackdown/execution of political opponents that led to the denial of the right of pursuing education for their relatives. The sociocultural and political issues in her past home leave permanent scars for Mahtab.

Furthermore, in her new home, she was unable to register in university owing to the fact that there was no one to take care of her children. While she had a great desire to study, structural constraints such as racialized/gendered wage differences did not allow her. The absence of social networks exacerbated her struggle. She was socially and economically confined, and felt that she did not have the opportunity to develop herself to her full capacity. While a family unit arriving in Canada often undergoes a significant economic decline, the availability and the cost of further education and/or childcare can be a limiting factor for Iranian immigrant women as the family needs to economize, and women’s education may not be a priority.

Notably, during the last decades, the cost of a university and college degree in Canada is getting steeper and tuition and other compulsory fees have grown to become the single largest expense for most students (Canadian Federation of Students, 2013). The dramatic tuition fee increases are the direct result of the rapid direction of Canada’s post-secondary education system away from a publicly funded model—through cuts to public funding by the

federal government and, to a lesser extent, provincial governments—towards a privatized system. Importantly, the burden of rising tuition fees has weighed far more heavily on the shoulders of low-income Canadians (Canadian Federation of Students, 2013).

Meanwhile, Plan International Canada launched the “Because I am a Girl” initiative in order to operate and promote projects for supporting “girls’ rights in the developing world” (Plan International Canada, 2014b, *The Girl Issue*, para. 4). One of the main goals of Plan Canada Campaign is to give girls equal access to education. As Plan (Plan International Canada, 2014a, *Girls’ Education*) states, there are several obstacles “stand in the way of girls receiving the quality of education they deserve” (para. 4) and most of these barriers are “unimaginable to people here in Canada, but to girls living in the developing worlds, it is a daily reality” (para. 5) and one of these barriers is the cost of education.

It is my concern that while the campaign was founded to encourage potential donors to invest in ostensibly helpless girls in the Global South, yet there were women living in Canada, for whom, what might supposed to be unimaginable, was their daily realities. While such campaigns seek to “end poverty” and “transform futures” by providing equal access to education, some Iranian immigrant women as the result of structural constraints are trapped in poverty, which did not allow them to change their futures in the ways they had desired. As earlier mentioned, education as a determinant of health must also be seen within the context of gender roles when the caring responsibilities particularly lack of affordable childcare was a prohibitive factor for pursuing further education.

Moreover, Iranian culture puts immense emphasis on education and there is continuity of privileging of education across homeland and diasporic contexts, therefore, the role of education in definition of Iranian social class could not be ignored.

Like other participants, social, political, and economic inequalities shape Mahtab's life. She had fled a society in which her basic human right, her right to education, was denied and she entered a society that "wants to make individuals responsible for themselves, rather than a country that says we create institutions to look after each other" (Ungerleider & Burns, 2004, p. 151). As Raphael and Curry-Stevens argue, "Embedded within our social and cultural norms is the myth of personal success, framing the individual as authors of our own lives. ...through this process, we become agents in our marginalization" (2004, p. 355).

## **Employment: A Central Issue**

With respect to employment, two issues emerged: first, exclusion/ unfulfilled expectations; and, second, job satisfaction/job insecurity.

The participants were unified in their beliefs that employment had a great impact on health and wellbeing not only as a source of income, but also as a means of identity formation:

Job is the essence of human being. It gives you personality, it gives you respect...unemployment hurts me [here]. (Arezo)

I liked my job [in Iran] ...and it satisfied me. ...it [job] gives motivation for the life...it is not just income. It gives you peace of mind. ...I could not find a job here. ...I am educated. I have experience. ... There are things that [are expected to] bring comfort [but].... (Atousa)

The participants also built a link between employment and social support networks, as well as sense of belonging. Roz said:

It [employment] affects your mental health. You think you are part of this society. ...I talk with my friends [at work] and I enjoy.

While education provides individuals with the skill sets necessary to enter the labour market, educational attainment is not often valued in conferring commensurate employment status in Canada for newcomers, in particular for immigrant women (see literature review). The cruel irony for many newcomers—especially skilled workers—is that while they are admitted to Canada on account of their education and work experiences, they are frequently prevented from using their education and/or experiences in the labour market; Iranian immigrant women whom I had the privilege to interview were no exception to the rule. Parisa went on to explain:

Here [in Canada] I am doing a job, which is not my job. It is an ordinary job that everyone without education can do it. Well, it hurts me. ...I liked my job there [in Iran]. I was a powerful manager, I knew my field, and I did my job [in my field]. But here I work [in a menial job], this [type] of work makes me tired. ...This job is not match with [my] education and experience, it hurts me and threatens my health. ...Canada accepts immigrants, so [Canada] has to think about her programs ... [Canada has to] change them [the policies] and let immigrants to be more comfortable.

The effects of devaluation of credentials particularly were felt severely by participants who worked in regulated professions where entry into them was strictly controlled. Parisa expanded her argument and told me that she did not understand why her credentials, obtained from a well-known educational institute from Iran, had not been accepted in Canada and why

she had to start from scratch. Using this argument, she criticised Canadian systemic policies for not recognizing the credentials earned in certain countries outside Canada and she built a strong link between the derogation of credentials and structural racism. As she noted, Canada prides itself on multiculturalism; however, by not recognizing foreign credentials, Canada excludes some workers from certain countries.

Parisa later added, “If I had known [it before coming here], I would have made another decision, might never come here.” She precisely expressed how finding a meaningful job might be a distant hope in Canada for some Iranian immigrant women. The gap between her expectations, dreams, desires and her lived reality loomed so great that it led to bitterness and frustration:

When a [professional] has come here, s/he must know s/he is not a [professional] anymore in Canada.

A wide disparity between expectations and reality was also addressed by Azadeh:

[Before moving to Canada,] you think here [Canada] is utopia, but [after arrival you find] it's not.

Generally speaking, skilled Iranian immigrants had no previous knowledge of the evaluation process and were wholly unprepared. Equally important, they encountered problems with providing documents from educational institutions and regulatory bodies in Iran, as well as having their credentials evaluated in Canada. Moreover, they found that this process was prohibitively long and drained their savings.

Restricting socioeconomic mobility not only affected the social and mental wellbeing of immigrant women as I argued earlier, it also had a great impact on their physical wellbeing:

I have to stand eight hours. I am not allowed to sit [emphasis] [I have] just half an hour break. Eight hours standing...it makes me tired...can you stand eight hours? ... One night I came back from the work. I had severe back pain. I could not sleep. I tried to [take some pills] and I fell down. All of my teeth were broken. ...I didn't have [insurance] coverage. I paid a lot of money [from my savings]. (Parisa)

For some of the other respondents immigration has offered new opportunities. For instance, instead of desperately trying to secure employment in her area of expertise in Canada, Mina switched her career, found a job in another field, while taking online courses. Her husband, however, could not find a job, so he went back to Iran and was working there. Needless to say his move might have eroded family support; however, he provided the needed financial support to enable her to pay for the cost of courses and/or other materials. Importantly, she was glad to get a job and satisfied with her work, even though it was outside of her earlier formal training.

Clinging to the belief in the superiority of Canadian educational system, the youngest participant, Azadeh—who had a university degree from Iran—was continuing her education as a strategy to gain access to the job market. By completing a Canadian university education, another respondent, Bahar entered the labour market in a job that satisfied her. She described:

[I know that] people who have families and responsibilities are looking for a job. And they want just job [to survive] but for me ...without attachment, I

want a job to give me reflexivity...it's not about the money per se, it's about how it [my job] fitting to my life style which is about flexibility, freedom, and having space to do many other things in my life.

Another respondent, Touran, applauded Canadian society:

I love my job...in Iran, I was fired [due to political activism] but here I have my job [I am working in my profession] ...so, I am very happy.

It is also important to note that feel of threatening the job and insecurity—brought up by some employed respondents—was detrimental to their health/wellbeing. Sahar explained:

I worked in a store. After few months they [the employers] had to give me [supplementary health] benefit but they fired me. I was waiting for that...I had never cried but [that day] I sat on a bench and cried. It put great pressure on me.

## ***Discussion***

All participants were agreed that employment was a source of social support and income, as well as a means of identity formation and belonging. These findings match those observed in the earlier studies (see literature review). While immigration provided new opportunities for some participants, most of the professional respondents faced barriers in recognition of their credentials and converting their educational attainment into economic earnings, both of which is embedded in the structural racism of Canadian society.

According to Galabuzi (2001), the mission of the Europeans who migrated to Canada to establish a white settler colony in the 1600s—which was followed by systemic policies of genocide, segregation, and economic exclusion of Aboriginals—informed the foundation and development of the Canadian nation; the legacy that still exists and leads to socio-economic

exclusion of racialized immigrants. Indeed, Canada—which is often portrayed as a “cultural mosaic” to celebrate the construction of “multiculturalism” as part of Canadian identity—implicitly establishes that other cultures are “multicultural” in relation to core dominant Anglo-Canadian core culture (Mackey, 1999, p. 15). In this vein, the institutionalisation of difference drew on pre-existing patterns that had originated from colonial projects and, therefore, would celebrate particular forms of diversity (Mackey, 1999). In other words, it is a way that Canada has propagated “a national persona ostensibly free of systemic racial exploitation and as a ‘raceless’ society” (Deliovsky, 2010, p. 22). However, “race thinking” is a structure of thought that reveals itself in the term of “Canadian value” and matures into racism by its usage as a political weapon (Razack, 2011, p. 8). Whiteness becomes a structural feature of privilege and an advantage to justify a cultural-political fiction that used to and still functions today for mass accumulation of wealth and power. In other words, racism just changes its appearance and adopts many forms while maintaining its fundamental structure (Deliovsky, 2010). Moreover, when race thinking “is annexed to a political project” and “unites with bureaucracy,” it becomes “an organizing principal” (Razack, 2011, p. 9).

As a result of historical racial discrimination, governing bodies and gatekeepers of Canadian professional organizations secure the most ideal and well-paid jobs for the Canadian-born and Canadian-educated (Bauder, 2003). Therefore, some participants were trapped in survival or menial jobs, or faced with unemployment. The above excerpts also draw our attention to what Siegrist and Marmot (2004) describe as a “psychosocial environment”—the socio-structural opportunities available to individuals to meet their needs of wellbeing and positive self-experience (p. 1465), which shows that the effects of employment status and quality of work are not confined to the “material” aspect (p. 1464).

Therefore, as a consequence of being prevented by society to experience approval and belonging, participants felt frustration, disappointment, and exclusion. In fact, denying their skills and their worth evoked feeling of inferiority, a sense of social alienation, and ultimately becoming “invisible” in Canadian society (Alcuitas et al., 1997, p. 28).

I also want to highlight that not having access to the adjudication process before migration coupled with unfamiliarity with existing services, resulted in more challenges than some participants anticipated. Building on the works of Spitzer (2009, 2012), I argue that the discrepancy between dreams and expectations of what life will be and the reality of one’s experience—embedded in the reasons of migration—might operate as a chronic stressor. Studies show that restricted opportunities for upward social mobility, shifting status, and prestige markers have a great impact on health outcomes and are associated with hypertension, lower immune function, and higher psychosocial stress (Dressler & Bindon, 1997; Sorensen et al., 2009).

I pause here to mention that, following Haraway (2000), when I talk about immune system or physiology, I mean “the coursing of blood and hormones and the operations of chemicals—the fleshiness” (p. 109) and “the materialized semiosis of flesh always includes the tones...of body, of bleeding, of suffering...and pain” (p. 86).

Equally important, workers in survival and menial jobs were less likely to be able to quit their jobs and more likely to accept unhealthy and abusive working conditions when keeping their jobs was essential to their/their family survival. Moreover, they confronted a reality of insecure jobs and limited access to supplementary health benefits.

Importantly, job dissatisfaction and job insecurity are both detrimental to health. As Duxbury and Higgins (2001) indicate, “Job satisfaction is the degree to which an individual feels positively or negatively about various aspects of the job” and is associated with mental and physical health (p. 18). Job insecurity was also an important factor, particularly for women in precarious employment, who faced constant uncertainty as a result of weak labour market regulation, work-related health risks, and their future employment prospects. It is well documented that job insecurity can increase the risk of mental problems and heart diseases. In fact, not only can unemployment be harmful to health, but unsatisfactory or insecure jobs can also lead to the deterioration of wellbeing (Wilkinson & Marmot, 2003). Consistent with the findings of other researchers (Lewchuk, de Wolff, King, & Polanyi, 2003), workers in precarious employment, in general, reported poorer overall health and higher levels of stress than other workers in standard employment.

Therefore, while social position and distribution of economic resources strongly influence wellbeing, it is not surprising that disparity between education and employment or income through downward mobility heavily affect part of participants’ wellbeing. On the other side, obtaining a satisfying job is among the factors that have contributed to Touran, Bahar, and Mina’s improved health status in Canada.

I close this part by highlighting this fact: “The sheer weight of evidence tells us that the isms are directly proportional to one’s employment opportunities” and “meaningful employment provides a pathway out of the shackles of poverty” (McGibbon & McPherson, 2011, p. 66) meanwhile it works as a part of interacting, intertwined, and mutually reinforced determinants that cannot be unbraided into any single strand.

## **Income: Poverty a Hallmark of Oppression**

With respect to income/poverty, five issues emerged: economic insecurity, transportation, inability to afford the cost of medicine and/or other health care services, leisure opportunities, and housing.

The stresses of economic insecurity or absence of resources were factors that influenced health and wellbeing of some of the women. I want to underscore that imposing new strict sanctions against Iran created more obstacles, particularly for low-income participants, in two ways: first, it became more difficult for women who relied on transferring money from Iran, to receive it for their survival; and second, it accelerated currency devaluation. Therefore, low-income situations must be viewed within the context of sanction. Mina explained:

I work here but I also rely on the money that is sent from Iran. You know how our currency is devalued.

Atousa who was living below the low-income line or in her words “in the margin” claimed:

I am still living with my savings ...it helps [me] to continue my situation but if this condition continues... living in very, very [emphasis] base...it will be too difficult. ...if you are in stress, it hurts your health, well it means that for your survival, you don't need to use some things [resources] that you don't like ...there is a food bank here but I am not a person for [using] it.

The unemployed participants wished to be employed for the fear of using the food bank or to avoid the stigma of receiving a welfare payment. Arezoo explained:

...it is very difficult for Iranians to use welfare. It is too painful and it hurts them. ...I prefer to work [to earn money rather using welfare payment]. It is good for the mental health. ... Everywhere you go, they [other people] know that you use this system. But even if it were hidden... I, myself, know that I use it, it hurts me. ...I feel bad. [I think] when I can work [emphasis] [why] I have to use it [welfare service].

Another concern for low-income participants was transportation:

At nights after finishing my job, when I go home I have to wait near twenty, thirty minutes for the bus. It makes me more tired. (Parisa)

Transportation also limited some women's access to health services:

I found a dental clinic, its service is not too expensive but it is far. I don't have car. I have just one day off and I do housework on my day off. I can't go there. If I had went, I would have been lost my entire day. (Sahar)

The cost of medicine and/or some other health services was a source of stress for low-income respondents:

I have had an eye disease. In Iran, I checked regularly by a specialist. [After arrival in Canada] I had bought my eyeglasses from Dollarama. [Then] I was forced by one of my friends to visit an eye specialist. I went there but I was asked to pay more than 300\$. It was a lot of money. How could I pay? From where? ... I left the clinic. (Sahar)

Meanwhile, Sahar tried to pay the cost of her husband's medicine and put the family's needs first. She added:

It is very difficult, a lot of cost, a lot of money. Too difficult.

Some respondents made a link between their income and leisure time. Parisa indicated:

I have to work [for long hours], so I can't visit my friends. I can't go to a park. ... I can't continue learning to play my [musical] instrument. Well, I can't make it for two reasons: I don't have money and I can't stop working [using time off work]; because if I don't work, I can't pay my bills.

Housing is another factor that was brought up. Six participants who were homeowners, enjoyed their living conditions. Some of them made links between health/wellbeing and the properties' facilities—such as an indoor gym and swimming pool—as well as decorating the home in a Persian style—in order to make a connection to Iran, possess a sense of belonging, and find a source of comfort. Roz made it vivid:

I have made my home in a way to bring comfort to me. When you enter it, you will feel that you get in Iran. It gives me a peace of mind. It's like a heaven and helps me to relate to my roots. This makes me happy.

A few have difficulty paying their rent or buying a property. Sahar mentioned:

I can't buy a house. I had applied for a mortgage but I was told that I was not eligible. Because my income was not enough...I pay a lot of money for the rent [each month].

Roya who, for a while, had been living in social housing as a result of her low income, described the characteristics of her place of residence in detail:

I was living in a house. [One day] I smelled an odour [so, I looked for its reason] and found a shed at the bottom of the staircase. I asked the superintendents for help. When they opened the shed's door, I saw a few big transformers. They were exactly under my children's bedroom. I asked them to change my residence. ... We moved to another place. [For a couple of days] I had gone out of the town. When I returned, I saw that all the basement and furniture was covered with mould. I called the superintendents. They came and washed everything. But I felt it was not a healthy place to

live, so I called Health Canada for help. They [the Health Canada] approved and I changed my house again. ... I knew the rules but others [who] faced with the same problem in the neighbourhood [and] didn't have information, stayed there.

Roya also made a connection between the neighbourhood and structural racism and sexism:

All people who lived there were immigrants or people of colour, there was just one white, a white single mom. ... There were better houses, better neighbourhoods, but there was a ranking. You could have accessed to it, if you had been a man and white.

Generally speaking, while the homeowners appreciated their living conditions; low-income tenant households faced the housing crisis where their low income imposed another hardship for them—a barrier to move into ownership, particularly for single women-led families.

## ***Discussion***

As a consequence of un/underemployment, four participants experienced considerable hardship resulting in a spike in their poverty rates. Moreover, economic barriers were linked to sanctions: reluctance of major banks to facilitate transactions, risks of lengthy delays in payments, and weakened currency—near 80 percent drop in the value of rial in 2012 (Moret, 2014) affected low-income participants who relied on the money transferred from Iran. Enhancing financial isolation of some participants entirely for the political structure “is neither rational nor fair” (International Institute for peace, Justice and Human-rights, 2013, p. 20).

Taken together, impacts of sanctions and unemployment/underemployment resulted in low income which, in turn, affected transportation, housing, leisure opportunities, as well as affording the cost of medicine and other services that were not covered by Health Act. I discuss transportation and inability to afford the cost of services in the next sections. It is important to indicate that a regulated social security system does not exist in Iran (Ghorashi, 2003); therefore, participants were often completely unfamiliar with this system. Moreover, from the standpoint of Iranian culture, Iranians generally do not seek services as that could cause them to lose face (Ghorashi, 2003). Consequently, as narratives indicate, the stigma of using welfare payments resulted in stress.

The stresses of economic insecurity or absence of resources strain health and wellbeing in many directions, affecting both the endocrine and immune systems (Wilkinson, 1994). Prolonged economic insecurity—including lack of permanent full-time jobs and income insufficiency—can be considered a form of emotional trauma (Wasik, 2006). Additionally, poor leisure opportunities are associated with deterioration of health (Sundquist, 1995).

Equally important, characteristics of one's place of residence constitute another factor that determines health (Lenthe, 2006) in two ways: first; damp and mouldy environments may cause a variety of health effects (Bryant, 2004; McGibbon, 2012b) and second; an individual's home provides "a place of refuge," a significant "source of prestige, status, pride and identity,"—which is frequently enhanced by home ownership—and where individuals "are socially and legally sanctioned to exercise complete control" which is another dimension of relation between housing to health/wellbeing (Dunn, 2002, p. IV). It is particularly important because social class plays a significant role in Iranian culture and, therefore, home as a source of prestige and pride can impact on the health of the participants.

It is also important to note that the roots of the housing problems lie in the political ideologies of individualism espoused by Canadian governments through cancelling previous programs for social housing and cutting the funds for new programs (Bryant, 2004; Shapcott, 2004). While the association between health and one's housing situation seems obvious, it is necessary to look at their intersections with the other social determinants of health and isms—such as income, gender, and racism, just to mention a few—where they often cluster together.

Before moving to the next section, to summarize what has been written so far: the findings indicate that most of the participants as a result of various factors such as leaving a hostile society, as well as having a meaningful job, pursuing further education, good housing, and sufficient income perceived that their health/wellbeing had improved or at least remained stable. On the other side, some of the married/divorced participants with young children, as a result of their dual responsibilities—raising children and taking care of housework, as well as engaging in labour market—were under tremendous pressure. Beyond the dual responsibilities, Canadian structural racism and discrimination—through derogation of credentials—forced most professional participants to carry out part-time jobs without employment benefits or to remain unemployed.

Equally important, as a consequence of the lack of affordable daycare, absence of extended family and social supports, and economic hardship, mothers were less likely to participate in language classes and/or continue their education to re-establish their careers or upgrade their skills. Significantly, unequal distribution of economic and social resources exerted enormous impact on the health and wellbeing of some participants. It is documented (Reiche, Nunes, & Morimoto, 2004) that the lack of social interaction, isolation stress, and

chronic psychological stressors related to workplace, family turmoil, housing, and neighbourhood through down-regulating of various parts of immune response have an adverse effect on health, leading to distress and disease. The next story illustrates this.

### **Disability: How I Have Become Disabled**

Before moving to Canada, I had a food allergy but health was not an issue for me. After several years [living in Canada,] health would become my big issue. ... I had come [as a refugee] with my husband and children here, and then we divorced. I divorced him and he divorced my children and [after divorce] never contacted them. ... I didn't have any family here, no one to take care of [my] children. I didn't have any source [for support]. I had to buy [groceries] and carry everything by myself. The store was far. I didn't have a car. Taxi was not affordable. ... [Few years later] I was diagnosed with a [bulging] disc which pinched my sciatic nerve. I couldn't rest because my children were young. It has never healed. ... Then I got [a bulging disc] in my neck. Now, I can't sleep at night because of the pain. ... I have allergy to some medicines [so] I have problem with using painkillers. ... I have always tried to stand on my feet with all [financial] limitations [emphasis]. It has made me tense. I don't know how to describe... it placed me under a strong pressure. I've become disabled. I have not been fit anymore. ... [Later] I was diagnosed with fibromyalgia too. Now, I am not able to do my daily routines. I am even not able to brush my teeth. (Roya)

Later, Roya went to explain how disability was a significant force continuing her poverty and straining her health:

I had tried to find a job [by myself] and sent my resume to as many as places I could, and I just got one interview. It was for working in a prison. I fled the prison, so how I could work in a prison. I would tear the paper. [Then] I [decided to] go to an organization [that worked for assisting people with disabilities] to ask for helping me to find a job. After a few months, they

offered me a job, to work as a security guard. But it was not fitted with my physical status. At the same time [the organization] found employment [in affordable situation] for some other disabled people who were in wheelchairs. Well, they were white.

### ***Discussion***

As previously mentioned, lone-parent families, in particular female-led, are more likely to struggle with longer spells of poverty. Therefore, changing Roya's family status was a determinant of movement into poverty; and poverty itself, and its duration are strong determinants of health and wellbeing (CPJ, 2012). Caretaking of children and household responsibilities, as well as deprivation from resources: living in a neighbourhood with limited public service—restricted transport and few stores as indicated earlier—absence of social support networks, and affordable child care; were other determinants that left her disabled. Moreover, disability, itself, resulted in further unemployment that made Roya's situation more complex.

The above narrative also reveals a subtext to invisible chronic illness – “a condition unseen by others” and the dilemma of self-closure of illness (Vickers, 1997, p. 241). While Roya thought that disclosing the illness might assist her in eliciting support from society to find employment; the subsequent events such as disbelief—as a result of her concealed symptoms—and hierarchies through grading disability and preserving the sanctity of white privilege, denied her right to employment. Failure or unwillingness to provide help as a result of a “pervasive attitude among those administering programs for people with disabilities that their ‘clients’ are trying to get more than they deserve” (Wendell, 1996, p. 42) and the focus on “overcoming” (Clare, 1999/2009, p. 2) disability when she was

expected to perform tasks, although “only at the cost of pain” (Wendell, 1996, p. 40) again “calls for a paradigm shift from the disabled body to a disabling society” (Dossa, 2006, p. 345). Indeed; this passage reveals that “[i]n large part, disability oppression is about access” (Clare, 1999/2009, p. 7) – access to equal resources and materials.

Moreover, I want to emphasize that it is difficult to create a dichotomy between the body (impairment) and disability (the social creation). Here I agree with Shakespeare and Watson (2001) that disability is a plural identity and it is also a complex dialectic of different factors. Following Wendell (1996), “I do not want to claim or imply that social factors alone cause all disability. I do want to claim that” (p. 42) failing “to prevent damage to people’s bodies” (p. 45) through unequal distribution of basic resources makes disability a social construct. However, emphasizing on social model, particularly in chronic illnesses, does not mean to ignore the role of medicine to alleviate pain, minimize the life-threatening consequences of these conditions, and improve the quality of life.

Finally, when we are talking about disability, it is important to not ignore the carers’ roles. As previously mentioned, three participants took care of their relatives with disabilities or illnesses. Notably, the narratives of both the carers and woman with disability, highlight the role of the state to provide adequate support to them: for the carers, the failure of the state to provide such supports resulted in feeling burdens on their shoulders; and for the woman with disability it resulted in marginalization and exclusion from the labour market and its consequences such as poverty.

Equally important, the relationships between people with disabilities and their carers were two-way ties. As above excerpt indicates, after becoming disabled, Roya continued her

fulfilling tasks as a mother and, therefore, highlighted the fact that a person with disability can be a carer as well, which contradicts the stereotypes of people with disabilities who are constructed as burden or solely care receiving.

### **Social Support Networks: Loneliness and Worries**

All participants were agreed that social supports networks had a great impact on the health and wellbeing. Touran affirmed:

Humankind is like a grape vine [we] need something to attach.

Some argued that lack of a coherent Iranian community in Ottawa/Gatineau was a tangible factor. Jawaher explained:

We have a community here. They are helpful, but we need a more coherent organization.

Generally speaking, the participants shared the experiences of loss of extended family supports and some mourned losses, blamed themselves or felt guilty for leaving Iran—as a result of not caring about their relatives. Meanwhile, they tried to build new friendships and/or sought out work colleagues as potential sources of social support networks—as previously mentioned. Arezoo indicated:

I worry for my sister [and] it hurts me. She is sick...I think I have to care of her but I can't. It is an important thing that really hurts me.

Roya burst into tears as she described:

I was waiting for my brother to join me here. He was so attached to me...everything was ready for his travel but [just before leaving Iran] he died...the death of family members especially when you are out of the country [Iran], never heals.

Receiving supports from their family members in Canada played a positive role for some of the participants. Roz, who entered Canada as a family class immigrant, brought up:

When I came here, my husband was working [in Canada] and had his own house. [So] I had a financial support. ... We [me and my husband] have shared the responsibilities...so I haven't been in such pressure.

However, it was not always the case. Mahtab another family class immigrant, who throughout her life carried the burden of caring for her family, explained:

I was raised in an open-minded family...they were warm and respectful, but he [my ex-husband] was so controlling. He did not respect me. I was always busy [with work inside and outside the house]. I was responsible [for everything]...

The constant presence of family members and friends in Iran brought the pleasure of company, feeling connected, and secure; however, in Canada, long hours of work and limited financial resources prevented some of the Iranian immigrant women from maintaining or re-creating social support networks. Sahar expressed:

Being in touch with people gives you energy. ...We went to parties [in Iran], but here we have lost many things. Our families, mothers, fathers. I don't have anybody here. ...I can't go to a party [here] because I don't have money.

Economic circumstances limited social support resources for some women; conversely, social networks were linked to finding jobs and further economic advancements. For instance, Roz and Parisa found a job with the help of their friends. These findings illustrate another layer of complexity of factors that influence the health and wellbeing of participants.

As previously noted, some respondents were overwhelmingly un/underemployed; therefore, undertaking the promise of providing financial assistance to their relatives for a period of time—as part of the process for obtaining a travel visa for relations to enter Canada—was out of the participants’ reach. Sahar who was living with her unemployed husband with a disability and her children—thus, falling under the category of “a single-headed household” (Dossa, 2004, p. 95) —noted:

I felt alone with a heavy burden on my shoulders. ...I tried a few times [to get a visa] for my mother, but it [visa application] was rejected. She was told [by the visa officer] that your daughter’s income was not enough.

However, when the financial situation was not a barrier, closing the Canadian embassy in Iran, which now requires travelling to another country to get a visa, and other hurdles such as not issuing the visa for other reasons also surfaced. Roz described her baby’s birth in Canada when her mother was denied a Canadian visa:

I was in the delivery room and really wanted to have my mother [beside me]. ... They [the family] are part of our lives. We need them such as everyone else.

Therefore, as a result of bureaucratic and political impediments and/or impoverished circumstances, it was not easy for some of the participants to maintain connections with their relatives in Iran.

### ***Discussion***

With respect to social support networks, four issues need to be elaborated on. First, as already mentioned in Chapter Two (Noh & Avison 1996; Spitzer, 2009; Stafford et al., 2010; Xu & McDonald, 2010), immigrants who settle in large metropolitan areas with a high density of immigrants who are from the same ethnicity, may easily find social support within their own communities. However, the Iranian community in the Ottawa/Gatineau area does not have a significant level of cohesion, therefore, this positive outcome did not come into effect.

Second, in a similar vein, for immigrants who have families already stabilized in their settlement area it might act as a preventive factor, which decreases the risk of poor health. Therefore, it is assumed that “family reunification arrivals are able to draw upon kin for support” (Newbold, 2005b, p. 82). However, this is largely dependent “on the reliability of support they receive from the sponsor” both mentally and economically (Dunn & Dyck, 2000, p. 1591). As two participants discussed, the presence of supporting family members, who were established in Canada before their arrival, had a positive impact on their health, but it had not been the case for another respondent who had also entered Canada as a family class immigrant and was faced with both emotional and economic challenges. Put another way, all three family class participants lost their extensive social networks upon arrival, meanwhile one reunited with her children and enjoyed their companionship that acted as a buffer to mitigate the previous loss. One other had a few difficult years as the result of her extensive family loss; however, her children’s birth and her supportive husband helped her to improve her health/wellbeing and returned it back to its pre-migration status. For the third one, her husband was neither supportive, nor nurturing. Their relationship was conflictual

and hostile, and it negatively impacted her wellbeing. On the other side, some economic or refugee respondents came with their families which positively affected their health. In fact, this finding corroborates the ideas of Spitzer (2011a) who suggests that the boundaries between different classes of immigrants are somewhat indistinct and fragile.

Third, all participants were agreed that one of the determinants that impacted their health/wellbeing positively or negatively was social support networks. Broadly speaking, the respondents shared the experiences of loss of extended family supports. Moreover, as a result of fleeing Iran as refugees or bureaucratic and political impediments and/or impoverished circumstances, it was not easy for some to maintain connections with their relatives in Iran which was an important source of suffering and worry that many times was recounted as a painful experience. Taking Ebadi's consideration, "the absence of loved ones...is a pain that times does not blunt" (2006, p. 78).

Fourth, the geographic or spatial contexts, including a physical distance for participants longing to travel to Iran or being keen to host their families in Canada—read as a barrier to social supports—and also lack of transportation—read as a barrier to access services/leisure as earlier mentioned—make another layer of complexity to the factors that impact health/wellbeing. Building on the work of McGibbon, I consider the spatial contexts of oppression as another determinant of health where I ultimately have "intersections of intersections" (2012b, p. 43).

I want to underscore how power imbalances can play an important role in the wellbeing of Iranian immigrant women when considering spatial contexts of oppression. Minister of Foreign Affairs of Canada, John Baird, at the sixty-seventh session of the United

Nations General Assembly (2012) stated, “The Preamble to the United Nations Charter reflects our collective determination to achieve ‘better standards of life’ for all humankind” (p. 3) and accepting the responsibility to “improve the well-being of all” (p. 3). Later for legitimizing the reasons of why “the toughest economic sanctions against Iran” had been imposed, he claimed, “our quarrel is not with the people of Iran, but instead with the regime that aims to silence their voices” (p. 6). This statement brings up two questions: first, whether sanctions “put pressure on Iran” (P. 7) or rather inflict harsh punishment on Iranian Canadians who have already faced economic hardships, as indicated earlier. Second, whether familial separation that Iranian immigrant women have to endure—whose “voices” are loud in my ears—is a way for advancement of “standards of life” and improving “the well-being”, or rather “all humankind” means something else.

### **Age or Ageism: Which One Matters**

All participants brought up that age was an important determinant, yet their arguments for doing so were very different. With respect to age, four issues emerged: aging process, age at the time of arrival, fear of aging, and age as a symbol of wisdom.

All the middle-aged participants who had been living in Canada for more than 10 years discussed that they could not ignore age. They indicated that upon arrival they were young, and for some of them getting older was accompanied by declining physical energy and experiencing some conditions like hyperlipidemia. However, they mentioned that it was part of aging, and, considering this fact, their health remained same. Touran opened up that aging was inevitable:

...it [aging] is like four seasons of life, you cannot change fall to spring.

Some participants expressed decreasing the level of energy by speaking about their dancing and hiking experiences:

Every week I went hiking. I was also dancing. I liked dancing. ...but now I think I have forgotten how to dance, it is because I've got older. (Sahar, mid-term refugee resident)

At that time [before immigration], I was a young girl, a hiker, no matter what [happened]...I went hiking. (Mahtab, long-term resident)

Age at immigration also played a significant role for the participants who immigrated during their fifties, in finding jobs and opportunities such as pursuing an education. Some expressed that they would have been more successful if they had come in their younger age. Difficulty in finding jobs echoed in Arezoo's statement:

I had applied for a job but they [the employers] did not contact me. After a while I went there and [asked them,] they told me, "We recruited these young [girls]". ... I was told that here [in Canada] age was not matter [for the employment opportunities] but it does. ... If I had come here when I was younger, I would have had more opportunities.

Participants also found age as a crucial factor for learning in terms of continuing their education or improving their language proficiency. As Atousa, an intermediate resident, said:

I know my first need here is language. I really want to speak [English] and fill this gap, but I know at my age, I cannot get everything, it takes more time.

Some participants expressed their worries about old age and fear of being put into a nursing home. Roz conveyed:

I worried if something is going to happen to me [I become sick], what will happen. In Iran you have family, someone who cares you. My mom had become sick and my sister decided to retire [early] to take care of her. She [my sister] is an angel, you know, [she is] out of this world, she is cornerstone of our family... but here...you know, life is different, you can't expect your children to take care of you.

For Bahar and Azadeh, the youngest participants, who were in their thirties, age meant wisdom, a positive factor that boosted their health:

I have accumulated so much experience and wisdom that I praise the path that I had. ...as I became older, I become more comfortable with my skin. And this is who I am and take it easy. (Bahar)

When you get older, you gain more experiences and solve the problems easier. (Azadeh)

## ***Discussion***

The aging process was mainly discussed and was a crucial element for the middle-aged participants residing for more than 10 years who experienced declining physical energy and/or physical conditions such as hyperlipidemia and joint pains. However, these physical ailments were not considered as an aspect to defining their health as poor. While age may operate as a factor, a low level of energy might be a result of stress, as both participants talked about their stressful lives' conditions: Mahtab had a stressful job, a very tense time during her last marriage that ended in divorce, and had difficulty in work-life balance; Sahar was relegated to a low socioeconomic status living with her children and her husband who

had a disability. It is documented that prolonged and extensive stress-related activation of hypothalamic-pituitary-adrenocortical stress axis can result in a distributed feedback regulation of this system, which is associated with a lower amount of energy (Siegrist & Theorell, 2006).

Equally important, age at immigration played a pivotal role for respondents who immigrated later in their life and intersected with finding jobs, improving language proficiency, and continuing education. This finding is similar to the findings of Shemirani and O'Connor (2006) who argue that older Iranian immigrants linked their age to limited opportunities. It is also consistent with Zietsma's findings (2007) that older immigrant women have much more difficulty in finding jobs than their young counterparts. Rasouli et al. (2008) discuss that age-related discrimination can be a reason that leads to lower levels of career adjustment for the older immigrant women. Painting Canada as a land of opportunities, therefore, is not trustworthy—at least for participants who entered the country later in their lives.

Fear of aging was another issue that was brought up. In Iran, the family has an important role for support of its members and it is also a fundamental source of help. Within the family structure, responsibilities are placed on the younger generation to provide care for elderly parents (Alizadeh-Khoei et al., 2011); however, social roles such as family roles are neither fixed nor immune to the structural pressures of the new society (Mahdi, 1999). Changing family structures might be a result of women's fear of aging.

Moreover, the outcome of working conditions in Canada might be attributed to performing of family roles, such as responsibilities of caring an elderly relative, all of which

can complicate the younger generation's situation at work. Additionally, it can be related to loss of extended family social supports, which is consistent with the findings of others (Ahmad, Shik, et al., 2004) who have reported that fear of getting sick was common among their participants due to their limited social supports.

Perhaps even more importantly, the existing power relations that continue to perpetuate false images and ageist stereotypes may have an essential role. In Iranian culture, age is perceived as a sign of wisdom and older people are respected (Alizadeh-Khoei et al., 2011); however, throughout the Western world, wisdom as a social role for older women is dismissed or ignored (Bassett, 2012). Therefore, the ageist assumptions contained within the aging discourses in Canadian society might influence how Iranian immigrant women defined age.

Put another way, ageism as a form of oppression is embedded in the predominant value system of Western societies—such as Canada—where productivity denotes individuals' social worth (Angus & Reeve, 2006; Bassett, 2012). As a result, it is the responsibility of individuals to not be a burden on society (Bassett, 2012). Therefore, women might see themselves declining and becoming dependent with fear of aging with a disability where “negative images of aging have an enduring vitality” (Angus & Reeve, 2006, p. 137) and formulate ill-health in old age (Bassett, 2012).

Ageism in arrangement of social and political manifestos often operates at a tacit level in a way that pervasiveness of stereotypes such as “burden”, “dependency”, “disability and ill-health” become what Biggs terms a “common-sense reality” (as cited in Angus & Reeve, 2006, p. 141). In such common-sense reality, the myth and unquestioned beliefs surrounding

aging is “widely spread, generally accepted, and largely ignored” and they are so powerful that limit the possibility for imagining on alternative realities (Angus & Reeve, 2006, p. 137).

Finally, as mentioned earlier while viewing age positively and as a sign of wisdom is a common cultural attitude among Iranians; it is not surprisingly that two younger respondents found age an enhancing factor that improved their health. To conclude, age is a pivotal marker of wellbeing that intersects with language proficiency, education, employment and therefore income; as well as social support networks and structural ageism. It is part of a complex whole that cannot be disentangled into any single aspect.

### **Immigration Experiences/Stage of Migration: It Is a Matter**

Immigration is a life-changing process and entails profound challenges, as Touran observed:

Immigration is a history. It is a stage of life that not everyone has a power to begin it.

Broadly speaking, the participants talked about the “push-pull” factors in immigration and their reasons for their displacement. While the participants I interviewed had a variety reasons for leaving the country, including family reunification, a better future for their children, and educational opportunities; most mentioned that socio-political factors were far important than economic factors as a reason for immigration. The respondents’ immigration can be seen as involuntary, voluntary or a combination of both. As Jawaher eloquently pointed out:

I decided to come here [Canada] to reunite my family ...but some people immigrated because they had to [do it] and they would really hurt ...however, there [in Iran] was [something like] a flow, many [people] made this decision [to immigrate], this flow takes you away...you don't know, what you are doing...I made this decision but I am still thinking why I didn't think more, I didn't do more research. But you know, how the situation in Iran is. Look! There is something that pull me here, the peace of mind.

Wallowing in doubt was expressed in some other narratives. Women explained their experiences here and there, the challenges that they had faced in their homeland and in the host country and still were not sure that their decision to immigrate was correct, as Azadeh told me with a laugh:

I don't know finally [immigration] brings fortune or misfortune.

Touran clearly articulated her reason for immigration: traumatic experiences of the Revolution aftermath, and painful transitions to life in the diaspora:

Some [people] go to this way but [they] do not know where they would go. ...it depends on why you come and what you want and whether you achieve your aim. ...how it makes you happy. ...I made a decision to [come] here; however, I was thrown. It was not my desire to come, but...that society didn't want me. I decided; it is the fundamental point, I decided [with emphasis] where to go; stay and die or leave and live. ...I didn't go to the airport with a bunch of flowers [to leave Iran], I left [Iran with the help of] smugglers with [my] young children. ... It was stressful... [Also] I lost many things, family, friends ... I've never back to Iran.

Some respondents told me that their states of health after migration were not always at the same level. Bahar, who was in a poor health before emigration, explained:

...when I came here, I was an international student which meant a lot of tuition fee that I had to pay. I didn't know anyone [emphasis] here...I couldn't work out off campus, and [on campus] work's opportunity was very limited. I have no one back in Iran to support me financially. So, I was on my own at every sense. You can imagine, so still the same for the first few years. It actually accelerated and I became more depressed and anxious. ... So, in the short-term, it [immigration] had some negative effect ...but in long-term, it has had tremendous positive effect in my health.

This issue also resonated in the voices of Azadeh and Roz who mentioned that their health and wellbeing, particularly mental wellbeing, were affected by immigration negatively in the first months/years upon arrival, respectively.

## ***Discussion***

[T]he families torn apart, lives wrecked and a generation traumatized, a diaspora permanently displaced” (Moaveni, 2005, P. 132).

Following Gushulak et al. (2010), I argue that pre- and post-migration experiences, the reason for immigration, and how respondents immigrated are important considerations. Moreover, like Thurston and Vissandjée (2005), I maintain that it is also essential to recognize that the stage of migration has a great impact on health and wellbeing. By virtue of access to more networks or different roles and responsibilities at different stages of immigration, participants might face different barriers or have more opportunities that each one can be health-damaging or health-enhancing.

As Lassetter and Callister (2009) argue, migration is a complicated decision making process and as the above narratives show there were more complex and “invisible elements” that influenced the decisions and choices of both refugees—mostly considered as involuntary

migrants—and immigrants to emigrate (Biidu, 2004, p. 237). Moreover, it is also crucial to note that in similar situations, different individuals choose or act uniquely, although the choices they might make “under enormous external pressure, they still are choices” (Biidu, 2004, p. 238). As Touran eloquently pointed out, she “was thrown,” however; she made a choice and decided between her death and life. Therefore, the neat division between voluntary and involuntary migrants is somehow difficult which shows another layer of heterogeneity of participants who was under the umbrella term of “Iranian immigrant women”.

## **Sexual Orientation: Who I Am**

Bahar described one of the reasons that immigration enhanced her health:

... [A]ll of my life in Iran, I thought, it was something wrong with me because everyone got married. I didn't understand why people get married, I was not interested in marriage and I was not interested in men. Then I concealed this sense [because I thought] I was abnormal and I had a disease. When I came here... I felt nothing is wrong with me. I am actually normal. I am just something else. You know, and from that moment I live my life. From that moment...instead of feeling that I was carrying a disease, I've become comfortable in my skin, so a lot of people were asking me, “Oh, it was so hard for you...to come out, how you did that?” And I said, “Are you kidding me? It was the easiest thing for me.” ...So, I live my life here. Now I am out ever where, at work, with friends, and have had a female partner. ... I can be who I am.

Later she expressed:

One of the biggest threat to my well-being and sources of my stress were the double identities that I had to maintain. One as a free lesbian woman in my

great adopted country, Canada, and the second as a single female who is not interested in marriage with my family and relatives in Iran.

Bahar also went to explain that:

I came out without any psychological trauma, you know, as a homosexual. ...I could never ever live happily and healthy in Iran [with laugh]. I can live my life...I feel, I can be lost in society. Here nobody is watching me. ... After several years playing games [with my family] I came out to them, they didn't accept me at first, but finally they told me, "We accept you and love you just the way you are."

## ***Discussion***

Iran is a unique case in challenging gender norms and has the second highest per-capita of sexual reassignment surgery in the world (Carter, 2010-2011). State allows transsexual people to undergo reassignment surgeries who are ultimately granted legal rights after that (Blake, 2013); however, it is a way for "normalization" (Carter, 2010-2011, p. 797) of whom "diagnosed" (p. 799) by the authorities to gain legal title. In fact, state policy on reassignment surgeries is a result of heteronormative gender norms where sexual orientation has to be clearly defined and aligned as per heteronormativity (Blake, 2013). In such view, being transgender, as well as gay, lesbian and bisexual is neither identity nor status. The findings further support the idea of Miresghhi and Matsumoto (2008) who argue that when individuals perceive their own culture as homophobic, it is associated with lower self-esteem and stress. Importantly, beyond the state and society, the above excerpt also points to how family might play a role in creating an atmosphere of uncertainty for Iranian queers, which is in agreement with the findings of previous work in this field (Carter, 2010-2011).

Following Minton and McDonald (1984), as well as Taylor (1999), I argue that it is important to notice that “coming out” is not just public self-disclosure of gay identity, it is the acceptance of one’s gayness as a positive aspect of self; therefore, homosexual identity formation has to be considered in a social context rather than merely on an individual level. Sexual orientation is one of the roles encompassing personal identity that influences every aspect of life. Identity refers to the ways in which an individual perceives, feels, and knows about the self and assigned to the consistency, unity, and continuity of one’s self-perception. Therefore, to attain homosexual identity, both personal and public identities have to be integrated in order to shape a single self-image. The decision to be un-closeted or to conceal the homosexual identity is detrimental to wellbeing. If individuals choose to hide it, they might feel that they are “valued for what others expect them to be rather than for who they really are” (Minton & McDonald, 1984, p. 102).

Additionally, the above excerpt draws our attention to what Singer terms as oppression illness (see Chapter Three) where the focus shifts from individual to the social origin of illnesses. As Bahar mentioned, she had come out without any psychological trauma because she could be lost in society and nobody watched her. In fact, Bahar felt that she was not stigmatized in Canada and, therefore, she was not required an adaptation effort that might threaten her self-conception. In other words, discrimination and prejudice could create a stressful social environment that might lead to feeling alienation and, ultimately, result in mental and physical problems.

In fact, the findings show that “coming out” has a significant correlation with sense of self-esteem, life satisfaction, and happiness, which further support the results of another research (Halpin & Allen, 2004). Moreover, a recent study in the U.S. (Miresghhi &

Matsumoto, 2008) examining the relationship between perceived cultural attitudes toward homosexuality and health among Iranian and American gay, lesbian, and bisexual individuals reveals that there was not any difference between Iranian and American participants when coming out was accompanied by the family support. Considering Iranians' collectivist values and importance of social support as a buffer to reduce stress among queer people, it is reasonable that Bahar defined her health and wellbeing in Canada as better than in Iran, when she particularly enjoyed the acceptance of host country and, to a lesser extent, her family. However, it was one factor among others that had a significant impact on her health and wellbeing.

### **Race/Racism: Why Do You Think We Are Different?**

When you go shopping, just because of your accent, they think you are stupid, you are crazy. ...sometimes they don't say anything...but you feel it when they look at you down upon. I am not stupid, I'm a human and feel it. I touch it. (Azadeh)

I look for whites, but I see just immigrants everywhere. ...who have to stand long hours at work with low wages ... Where do whites work? In big companies? ... It is not my accent, my accent is abused to insult me. They want to tell me, "You are no body. You look like me, your face, your hair colour, everything. But we know, you are not like us." (Arezo)

Some respondents strongly felt that they were targeted and their experiences were fraught with personal racism. They considered themselves as an "other," based on a variety of factors, including names, accents, veils, and national origin—usually viewed in the interpersonal sense:

One of my identification cards have a veiled photo. Many [people] looked at it and [then] looked at me [without veil] and happily told me, “You must be happy now.” But they don’t know my history. I felt humiliated. (Azadeh)

She added:

I went to a doctor with my husband. She treated us badly. I felt that she thought, “They are Middle Easterner.” Then she asked me to take off my dress. She was looking for some bruises in my body. She thought my husband violated me. It really hurt me. It was my first experience here and it was so bad. ... We [my husband and me] have tried to build a good relationship with each other, an equal relation. We have shared all responsibilities with together. Then you see that a doctor who is one of the representatives of this society treated you such that. It’s so humiliating.

Following Razack (2011), I argue that “Middle Eastern looks,” (p. 32), accents, national origin, and Muslim names provided good reasons for why participants were assumed to be pre-modern and “imperilled women” (p. 5) who need protection from their “hyper-patriarchal men” (p. 4) by “civilized Europeans” (p. 4).

Azadeh continued:

Racism exists but it’s very subtle and has different levels. [During the first days of my arrival] I went to an organization and a man who worked there asked me very angrily, “Are you a refugee?” and I told him, “No, I came as a skill worker.” And his manner suddenly changed and became good. I thought, “What’s the difference between me and a refugee? He might believe that a refugee uses the country’s resources.” Such things hurt me.

The above narrative indicated that not only a hierarchy of “social distance” exists (Danso, 2002, p. 9)—the geographic region where immigrants come from, but there is also a

hierarchy of immigrant class, which continues to see and treat refugees as “unwanted additions” (Danso, 2002, p. 7) and “unwelcomed others” (Danso, 2002, p. 3).

Azadeh added:

Here, people do not know us, they think we are terrorists, we are poor. They don't know Iranian culture. But everywhere news and the media show bad things about Iran. My country is good, it's nice. I defend it, but then I think “If it is good, what am I doing here?”

Mostofi (2003) explains this situation:

Iranian diaspora immigrants live in an awkward position. They pine over a home they can never become a part of because the Iran of their memories no longer exists, and they reside within a state they must adapt to for survival. (p. 698)

Building on the works of Gonzalez and McCommon she concludes:

symbols of Iranian culture such as ... history, domestic values and kinship ties, and etiquette can serve as reminders of their origin while helping ‘to establish who we are and who are they ... and [also] to shield them from an often hostile receiving society.’ (p. 691)

Some respondents were aware of racism, meanwhile tried to show their allegiance and loyalty to Iran:

Here, people think that Iranian women are dependent and abused by their husbands, but in Canada [white] women abused [too], more mentally...some women had to live in a shelter. They [people in Canada] have to know that Iranian women are independent, educated, and powerful. Many husbands and wives in Iran have been living equally with together. ... [So] I've always tried to show to my colleagues that we [Iranian] are good people. I've been

succeeded and everyone respect me. ...I always miss Iran, its streets, its alleys, its people, culture, bazar, my root is there, I can't [forget] my root...it's my soil. I've decided to go back to Iran later, when my children will completely settle here. (Roz)

Like Noh et al. (1999), I maintain that forbearance had a stress-buffering effect by reducing the adverse outcome of perceived discrimination—emotional and mental stress—and this response was augmented among those who had strong attachment to traditional ethnic values. Indeed, a well-developed racial identity, as well as its pride and the belonging dimensions may serve as a coping mechanism and ameliorate the pain of ostracism (Carter, 2007); although it is not sufficient for all (Brondolo et al., 2009). Following Moghissi (2003), I argue that participants, as a result of sense of not being accepted or tolerated by the host country, felt that they had to be on their best desirable and acceptable behaviour, to work harder, to complain less, and to cling to a folkloric identity to wall themselves off from the dominant host culture. In accordance with other researchers (Hesse-Biber, Howling, Leavy, & Lovejoy, 2004), I also argue that the ability of individuals to recognize the racial stereotypes and negative evaluations of their group then may act as a protector, meanwhile internalization of the positive values resulted in better psychological health.

Some participants argued that they had never felt that racism existed in Canada:

They always treat me well. I've never felt such things. (Atousa)

Some of the respondents were reminded of the situation of Afghans and Iraqi refugees in Iran.

Racism exists [in Canada] but it's subtle and hidden. Do you know why? I tell you. Because if someone does such thing, there is a law against it and

you can complain. ... I want to tell, it exists here but in compare with Iran and how Afghans were treated... (Touran)

Afghans were very bad treated in Iran and also Iraqis who entered Iran [as refugees]. However, they [Iraqis] were Iranian [emphasis] in one generation. ... If they [the media] want to destroy the picture of any country, they find a weakness to use it. (Arezoo)

## ***Discussion***

The above passages provoke five arguments: first, some participants might recognize racism “as a fact of life” (Noh & Kaspar, 2003, p. 234); and second, discussion of racism might evoke stressful recollections. Therefore, participants might try to minimize or deny some aspects of their experiences (Brondolo et al., 2009); no matter what, both are the ways for coping efforts (Brondolo et al., 2009; Noh & Kaspar, 2003). As Carter argues, “To live through a lifetime of racism in many areas of one’s life requires a certain amount of denial. When the denial becomes loss of memory for the event(s), this could be a sign that the event was traumatic” (2007, p. 93).

Third, followed Moghissi et al. (2009), I argue that recounting the discrimination against Afghan and Iraqis refugees—during the time many Iranians emigrated from Iran, this country hosted near three million Afghan and Iraqi refugees, which makes its migration history unique (Chaichian, 2012 ; Naghdi, 2010)—might reflect the constitution of an interracial and ethnic hierarchy, particularly in times of economic hardship which draws attention to the fear of having to share limited socioeconomic resources with those considers as others.

Fourth, some respondents discussed that the media and pervasive discourses had great influence on how Iranians are portrayed. It is well documented (Galabuzi, 2001) that the media is one of the most powerful institutions in Canadian society that perpetuates racial ideologies, defines communities, and creates images that becomes realities.

Fifth, the findings are consistent with others (Danso, 2002; Edge & Newbold, 2013) who argue that today, in Canada, most discriminatory encounters are elusive, subtle, and systemic or what Danso termed “courteous racism” (p. 9) rather than overt forms which can be more difficult to detect and evaluate. However, racism and racial discrimination “must be acknowledged as a pervasive and continuing reality” (Ontario Human Rights Commission, 2009, p. 4). While the awareness can be exhausting and elicit distress, it may be a remedy for gathering the strength to avoid being denied rights (Brondolo et al., 2009).

To close this section, racism as a determinant of health through stress of racial discrimination, as well as institutional racism—which is documented in Canada’s “normal ways of doing things” (Levy et al., 2013, p. 6), which was previously mentioned—by limiting socioeconomic opportunities and access to material and societal resources negatively influenced the health of some participants.

## **Weather**

In general, the clean air and blue sky of Canada entirely satisfied the participants—particularly who left Tehran, the capital of Iran, and with a lesser extent other major urban cities, as well as those who came to Canada in recent years. Toxic smog and traffic jams of Iranian cities were stressors that some participants mentioned. Azadeh described:

We always got caught in [a traffic jam]. I could not tolerate that and its stresses anymore. I am more relax here.

Mina, who was diagnosed with cancer a few years before moving to Canada, explained that she took a medicine that caused severe side effects, she continued:

When you live in a bad weather condition, you know what I mean, the air pollution, their [the medicine] [side] effects get worse. ... Here, weather has an effect on happiness [positively]. ... I have better feeling here.

For some participants, the transition to the prolonged Canadian cold winters was completely unpleasant, and the length of residence was not an important indicator. Mahtab, a shift worker, expressed:

Sometimes after finishing my job, when I wanted to return home at night, I had to warm my car and clean it from the snow. It was too cold. Sometimes I cried. I was crying and thought what kind of the job it was.

Some made a link between the weather and social support networks. As Parisa mentioned:

Well, the long winter makes me a little depressed, especially when we are not with our families and we are far from them.

Furthermore, she drew a connection between weather and healthy behavior such as exercise. She explained when the weather condition allowed her, she went out for walking but in winter it was impossible. She recounted:

You know, exercise [positively] impact physical and mental health. I can't go to the gym [in the winters, because] I don't have money to pay for it ... [also] I don't have a car.

Some considered that their muscular aches or joint pains exacerbated during the winters. Roya explained:

During winters when the weather turns cold, the stiffness of my muscles becomes worse and I feel more pain.

Some participants were afraid of falling down, therefore, they avoided going outside as much as they could:

I prefer not to go out in winter. You know, in my age my bones might break easily. (Atousa)

## ***Discussion***

Considering the fact that especially in Tehran during cold and windless days a thick layer of smog is trapped over the city, it is not surprising that six participants strongly argued that one of the reasons for improving their health/wellbeing is the Canadian fresh and clean weather. The contaminant condition makes Tehran and some other Iranian towns among the worst air-polluted cities in the world (Davidson, 2013; Naddafi et al., 2012)—the situation has grown worst as the result of sanctions on Iranian imports of refined gasoline that forced the Iranian government to turn to low-quality alternatives (Davidson, 2013). Moreover, it is also documented that both outdoor air pollution (International Agency for Research on cancer, 2013) and perceived traffic stress (Song, Gee, Fan, & Takeuchi, 2007) are associated with lower health status.

On the other side, six participants perceived Canadian winters as a determining factor that decreased their health/wellbeing not only emotionally, but also physically. They argued that long and harsh winters posed a physical hazard for them and limited their physical

activity which was particularly intersected with transportation, age, and income. This finding is consistent with two other studies: first, Stewart et al.'s (2011) findings indicate that winters in Canada were a challenge for immigrants who were 55 years and older; and second, Elliott and Gillie (1998) discuss that harsh climate was an important factor that negatively influenced Fijian immigrant women.

## **Health Care Services: Several Barriers**

With respect to health care services, I got different responses. One participant identified the Canadian health care system as one of the main determinants contributing positively to her health status change; however, she also expressed negative views about Canadian health care services. Azadeh articulated her conceiving reason:

If you will be diagnosed with a disease such as a cancer in Iran and you do not have insurance coverage, you have to die. But here, great part of it [the costs] is covered. Here they also have better equipment.

It was also echoed in Touran's voice when she made a link between her granddaughter's disease and the expense or scarcity of some medicines in Iran that got worse after sanctions. She said:

If she had lived in Iran, I do not know what might have happened. So I look at my living [situation] here from this point of view, I lost something but gain something else.

While some participants were generally satisfied with Canadian health care services; most of them argued that there were several structural reasons for dissatisfaction.

Language was considered as a barrier to care by some respondents and when it was an obstacle, impacted every stage of the care process including the medical appointment, laboratory services, and translating letters from the hospital:

There is a woman in the laboratory. She is very impatient. I always hope that when I go there, she won't be there. ... [Because while ago] I was there and I didn't understand what she said. I told her that my English wasn't good. She said, "Ok. Ok." But she became neurotic. (Arezo)

Lack of familiarity with Canadian health care system or information centers was expressed as another barrier. Moreover, presence of interpreter for overcoming linguistic barriers was neither helpful, nor satisfying. Azadeh explained:

I was sick. I did not know how to get an appointment. Some people at the language class told me that there was an organization that could help me. I called them and they got an appointment. I also told them that I would need a female interpreter. ... My scheduled appointment was changed and a male interpreter came with me. I know him and I was so uncomfortable to talk in front of him to the doctor.

In addition, children were sometimes asked to play the role of an interpreter. Discussing intimate health details in the presence of their children was occasionally problematic. Touran said:

My daughter was my interpreter. Doctor asked some questions and my daughter found that we [my husband and me] had a problem. She asked me why we [her parents] were continuing to live with together. I told because of you. ... Later we divorced.

Some participants focused on early discharge from the hospitals and how it could be problematic. Roya mentioned:

I did a surgery while ago and stayed in the hospital for seven days. But now they discharge patients very soon. There are good equipment in the hospitals and someone who checks you.

As a result of early discharge from the hospitals, some participants extended their caregiver roles beyond their families into other women:

I've known a woman whose job is cleaning the houses. I met her in my doctor's office. She had to have a surgery but she did not have any one to care her after discharging from the hospital. I told her that I could help her.  
(Mahtab)

Some of the participants did not trust the services:

I am not happy with [Canadian] health services. I don't trust them. I feel they are not looking for the reason of the diseases, everything is superficial.  
(Mahtab)

The expense of consultations, medicines, and some other services were considered to be other barriers to accessing health services:

I had to take some medicine regularly. They are very expensive. If [one day] I can't afford my medicine...I will never ask my family in Iran to help me. I have to stand on my feet. (Parisa)

One respondent explained that the proportion of funds borne by the state has dramatically declined:

The government has cut most of the funds. My doctor had sent me for rehabilitation. It helped me but I can't use it now [because] it's not free of charge. ... [Previously] if you had some symptoms they [doctors] would sent you for tests. But they do not do it now. Funds are cut. [So] you will

diagnose at the latest stage [when] treatment becomes more costly. It doesn't make sense. (Roya)

Some went back to Iran for accessing services, particularly for visiting a dentist:

I have an option. If I need, I will go back and visit by my dentist there.  
(Mina)

Lack of same-sex provider and discomfort was another issue that brought up:

My first physician was a man. I was really not comfortable with him. I was looking for a female doctor and [finally] found one. (Roz)

Lack of control in the referral process was another barrier that respondents had difficulty overcoming. As a consequence, some viewed family physicians as gatekeepers that restricted their access to specialist or costly services. It is important to note that it might be a result of the differences in home and host health care systems and different expectations of the services:

In Iran, where they think it is uncivilized, if a woman wants to be visited by a gynecologist, she can do. Here I have to insist my family doctor to refer me to a gynecologist. (Mahtab)

I had headache. ... The doctor asked a few questions and gave me medicine. He did not do anything for that [my pain]. I thought it would be better for me to be visited by someone who had more knowledge. I am not a person to use medicine. ... I [also] have allergy to some medicine. I told him that some tranquilizers created hallucination for me, but he didn't listen. (Arezo)

I asked my doctor to order a blood test but s/he said you have to wait for one year. It is a rule. (Parisa)

Some found pamphlets or posters useful:

My doctor didn't ask me about my child's movement. But I saw some posters on the wall. There was written, "If your child doesn't move, tell your doctor." Then I told her. First she said, "You can go [now] and when you'll come back next time talk about it." But suddenly she decided to write an [ultra]sonography. ...then they found my child was at risk and I underwent surgery. ...that poster saved my child's life. (Roz)

Bahar needed to disclose her identity with her health care provider.

She [my health care provider] was very accommodating...gave me a good pamphlet which was very nice.

Some decided to put off visiting physicians, to get help from other resources such as the Internet, and to rely on themselves to maintain their health or deal with health issues:

I don't personally appreciate the whole health care system. It's not holistic, it's very mechanical and symptom based. ... I think, it's a ridiculous education system that doctor[s] don't look at you. You go there and they are typing in their ... electronic system. ... I'm a human, look at me. ... So, I find it so inhuman. ... I don't know how sustainable such a model is. I've decided to take my health [in] my own hands. ... So, I think it is my responsibility to take care of my health and I don't rely on [Canadian] health care. (Bahar)

Three-month waiting period for health insurance was another issue that frustrated some participants, sometimes indirectly:

I brought my medicine for the first few months. But one of my friends came here [as an immigrant] and became depressed. I brought her to a clinic and she paid a lot of money. (Parisa)

Long waiting times to get an appointment and difficulty finding a regular family physician were other issues:

I had to undergo a surgery. I waited for three years, but I know it was not urgent. (Atousa)

After so many years of being in waiting list, they called me and said, “Oh, we have a family doctor for you!” [And] I told them, “You don’t have any idea how happy I am.” [With laugh] (Bahar)

Fear of finding a disease or believing that breast and cervical screening were not necessary, or more harmful than useful were resulted in underutilizing the services:

I’ve never done these tests, either there, or here. If they find something, it will create stress. (Sahar)

## ***Discussion***

With regard to health care, participants varied in their perceptions of health changes attributed to health services. Five participants reported that it had not affected their health but seven indicated it had improved or worsened their health and wellbeing. Owing to enhancing their/their family health, two factors emerged: first, coverage of most hospital and physician costs; and second, limited or scarcity of medicine or equipment in Iran as the result of sanctions. Two issues need to be elaborated on: first, Iran do not have a universal health care; therefore it was a source of concern. Second, while medicine is exempted from sanctions legislation, other factors such as restrictions on shipping, Iran’s Central Bank, insurance and reinsurance bans, impact on the country’s ability to import medicine, pharmaceutical, and hospital equipment that negatively influence civilian health (International Campaign for

Human Rights in Iran, 2013; Moret, 2014). Therefore, not surprisingly, two respondents believed that living in Canada and access to health care services and medicine might be a factor for maintaining/improving their or their family health, access to the basic rights that they were being denied by the new worldwide sanctions, as well as Iranian government's health policy mismanagement.

The findings demonstrate several structural barriers to health care services including: difficulty in communication, lack of knowledge of the Canadian health care system, cost, distrust, the difference between home and host country health care services, physical access difficulties/transportation, hetero-normative assumptions and racist attitudes of health care providers, poor referral to specialist, long wait times to get an appointment, difficulty finding a regular family physician. These barriers mirror the findings of previous studies that have examined the obstacles to access to health care services among immigrants (Reitmanova & Gustafson, 2007, 2008; see also literature review) and/or Iranian newcomers (Dastjerdi, 2007, 2012; see also literature review).

Shorter hospital stays were significantly narrated by women who had to care themselves after discharge as a result of loss of social supports. Cost of medicine/services and transportation/physical distance were predominantly recounted by low income participants who also did not have a supplementary health plan. Research shows that dental plans are not available to 74% of low-income employees in Canada, while in many European countries, it is part of national health plans (Mikkonen & Raphael, 2010).

It is worth indicating that “universal access to healthcare is now a core Canadian value,” however, the “translation of the concept of universality” needs to be unpacked

## Chapter Five: Findings - Healthy Behaviours/Coping Strategies: It Is Not Cigarette That Kill Me

(Galabuzi, 2004, p. 246). Since the last decades, due to structural racism, the socioeconomic status of racialized immigrant women has worsened and resulted in marginalization and exclusion. According to Galabuzi:

The extent of exclusion is expressed through the gap between the universal access to health care and the reality of unequal access to health service utilization. ... It is the gap between the promise of citizenship and the reality of exclusion that represents the extent of social exclusion and the unequal impact on the well-being of members of racialized groups and immigrants in Canada. (2004, pp. 246-247)

Put it another way, the phrase “immigrant woman” is a term that refers to a legal status but encompasses a social criteria as well. An immigrant woman is a person whose status as a permanent resident and ultimately a Canadian citizen provides her with many rights—such as universal access to health care; however, her social status is absolutely something else (Miedema & Tastsoglou, 2000). Following McGibbon (2012a), I argue that social exclusion through a system of various barriers—employment, income, supplementary health insurance, racism, and time away from work; just to mention a few—and cutbacks of some publicly funded health care are two key oppressive practices that limited access to health services for some participants which jeopardized or had the potential to jeopardize their health.

## **Healthy Behaviours/Coping Strategies: It Is Not Cigarette That Kill Me**

The physical activity levels remained the same or decreased; with a single exception, who identified considerable changes in access and ability to exercise for women as the reasons for her argument:

[In Iran, there aren't] enough opportunities, but here we have so many possibilities. (Bahar)

Generally speaking, the participants did not engage in unhealthy behaviour such as smoking. One respondent was a smoker, however, the average number of cigarettes smoked per day did not change after immigration. One other rarely smoked in Iran, but she quit here as a result of cost. By their knowledge brought from their home country and obtaining information from their colleagues and children, as well as the media and internet in the host country they tried to sustain their/their family health by consuming healthy food. Some enjoyed greater variety in their diet. Apart from experiencing the diversity of foods in Canada, some argued for consumption of fruits and vegetables they changed their daily choices to maintain their health. Azadeh explained:

We have more variety here. But in Iran we ate more fruits. And they are expensive here. So we've bought more carrot and broccoli.

More importantly, the participants found and used a variety of strategies to maintain their health and wellbeing:

I've never wanted to play the role of victim. ... I've learned several arts by myself. One of my work won a prize. (Roya)

I often go to swimming pool. It is good for my health both physically and mentally. I enjoy it. (Jawaher)

[After my diagnosis] I enjoyed staying at home, going to restaurant, spending my time with my family, doing things that I didn't have time to do. (Mahtab)

Some engaged in volunteering to sustain their health and wellbeing:

I enjoy helping people. I am part of a volunteer group. I am satisfied with it.

(Atousa)

Some listened to music, read literature and poetry, sang, and danced to sustain their health:

I read the books and listen to music. It helps me. (Parisa)

Interestingly, centrality of the health of family as a unit echoed in some accounts:

[After my granddaughter's diagnosis] I started working out. Every day for more than hour. I had to maintain my health. I needed to stay strong to support my family. (Touran)

I always energize myself. I give myself hope. I always say, "Tomorrow will be better." I transfer hope to my children. I am sure that tomorrow will be better. (Sahar)

I want to be a part of the society. I have to know what is happening or will happen here. ... This is my country too, not just an official word. There is a difference, an important difference between, just to be here or being an actor. It is my right. (Azadeh)

### ***Discussion:***

With a single exception, other participants' physical activities were either diminished or unchanged after immigration. Notably during the last decade in Iran, the number of men and women engaging in physical activities has significantly improved: lack of public awareness, air pollution, and shortage of facilities, particularly for women, are still significant factors contributing to low physical activity levels (Nahid, 2008). Therefore, coming from a country with lack of access to facilities and more importantly lack of

awareness might be a reason that respondents did not engage in such activities before coming here. However while a few were active, after migration, changes in socioeconomic status, long hours of work, caretaking responsibilities, and harsh winters worked as the barriers that resulted in a diminishing of their physical activities. Researchers (Delavari, Farrelly, Renzaho, Mellor, & Swinburn, 2013) in Victoria, Australia, argue that after immigration, Iranian immigrant women became more active; however, students, medical doctors, young, and high income participants were overrepresented in their study. The only respondent of my study who followed the similar pattern was also young with high income. Equally important, participants in general, tried to sustain their health by both consuming healthy food and not engaging in unhealthy behaviour. The findings are similar to another study (Ng et al., 2005) that indicates non-European immigrants are somewhat more likely than their Canadian counterparts to have become physically inactive during their leisure time but less likely to adopt unhealthy habits. Additionally, the findings are consistent with another study (Perez, 2002) that reveals immigrants, generally, consume fruits and vegetables more frequently and smoke less than Canadian-born population.

Perhaps more importantly, to portray Iranian women as wholly vulnerable to the detrimental effects of social exclusion and material marginalization would not be accurate. As findings illustrate, they were knowledgeable and critically identified the links between their lives and social structures, as well as demonstrated their resilience in myriad ways. Women's resilience "converts risk into challenges" (Bieser, 2010, p. 4) to prove that they are not passive or victims.

According to Rutter, resilience refers to one's ability to resist serious risk experiences and overcome the adversity and stress; therefore, it can be viewed as protecting coping

strategies that individuals develop to produce a positive outcome despite those experiences (2006). At the heart of coping is active responses to forces and external life-strains that impinge upon them (Pearlin & Schooler, 1978).

Consistent with findings of Miedema & Tastsoglou (2000), some respondents found volunteering—inside/outside their community—as a positive program outcome; a safe space for socializing, an opportunity to build networks, a way to become politically active, and an environment to learn how to navigate Canadian society.

Reading poetry and literature, listening to music, singing, dancing, and exercising were other ways that helped participants to sustain their health and wellbeing. Building on the work of Reed (1998), I maintain that dance can be a potent symbol of identity, a way for “expression and practice of relations of power and protest” (p. 505), a “site of desire,” and “a genuine threat of political resistance or rebellion” (Reed, 1998, p. 506).

Moreover, for centuries Iranian women have relied on words to transform reality, as their written words are the most powerful tool they have to protect themselves (Ebadi, 2006). Therefore, what was recounted in this study, the words of Iranian women were “their magic carpets” and “their wings” (Milani, 2011, p. 242).

# **Chapter Six: Conclusion, Recommendations, and Limitations**

## **Conclusion**

The history one is born into is always so naturalized until you reflect back on it and then suddenly everything is meaningful—the multiple layers of intersection in a landscape of social and cultural histories all of a sudden pops out. (Haraway, 2000, p. 5-6)

At the beginning of this thesis I posed these questions:

- How do Iranian immigrant women residing in the Ottawa/Gatineau area define health/wellbeing?
- Does immigration impact on their health/wellbeing? If so how?
- What do they perceive as determinants of their health?
- What policies, programs, and services could best support their health/wellbeing?

In this chapter I come up with the answers collected from the data.

Broadly speaking, the participants defined health in a holistic sense, incorporating physical, mental, and social aspects, by highlighting the importance of mental wellbeing to one's overall health. The majority of participants were in good health before migration and the results of the study revealed that a third of the respondents believed their health/wellbeing had remained stable, four of the participants mentioned it had improved, and the other third argued it had worsened—these perceptions were neither linked to

immigrant/refugee category nor to the length of residence. Therefore, one of the important findings of this exploratory research is that two-thirds of participants remained at the same level of health or reported improved health status after expatriation thereby disrupting the well-documented observation that the health of immigrants deteriorates over time.

Significantly, changing the health status was not attributed to deleterious health behaviours, such as smoking—as its pattern was drastically unchanged. Additionally, respondents combined their knowledge about healthy food gained in Iran with gathering information in Canada through various resources to maintain their health. With respect to physical activity, its patterns remained unchanged or decreased with single exception who explained that more opportunities for exercise in Canada had a great positive impact on her health. Notably, half of the respondents expressed concern over the harsh and long winters, as well as the time and cost as the barriers associated with accessing certain types of physical activities such as swimming pools and gym centres. Broadly speaking, the results illustrate that risky behaviours were not a valid candidate for explaining the change in health status of participants after migration.

The participants identified several intersecting variables as contributing to their health status including: gender, pre-migration experiences, stage of immigration, age, age at the time of arrival, ageism, language proficiency, education, employment, working conditions, income, leisure opportunities, housing, physical distance, transportation, social support networks, racism, homophobia, disability, weather, and health care services. However, none of these overarching aspects can be regarded as simple predictors of health and wellbeing. Indeed, interactive gendered, socioeconomic, political, and environmental determinants in the both home and host countries—when, how, and why they migrated as well as their

settlement experiences—intertwined with the social indicators to impact the health and wellbeing of Iranian immigrant women whom I had the privilege to interview.

These determinants, particularly structural phenomena – “isms” – were the “causes of causes” that contributed to the shaping of health and wellbeing of Iranian immigrant women. These factors were tightly integrated and simultaneously operated in a complex manner. For instance, pre-migration sociopolitical events made a barrier for pursuing an education in the home country which intersected with other barriers in the host country such as care responsibilities and economic hardship, as well as lack of an affordable childcare program, funding for post-secondary education, and social support networks that in turn were interconnected, but not limited to, further employment, working conditions, and income—which made the situations even more complicated.

The participants generally conveyed “the message that life in Iran was not a bed of roses—for some there were more thorns than roses” (Dossa, 2004, p. 165); similarly, living in Canada neither brought “mythical”, nor “perfect happiness” (Moaveni, 2009, p. 332). While some fled the forced visible veils they trapped in “invisible walls” of Canadian society (Dossa, 2004, p. 29). They just negotiated a place on a country where themselves and most importantly their families felt more comfortable and had more opportunities.

While participants shared some similar experiences, the realities of women’s lives and their reasons for change or stability of their health status were not identical. Importantly, their perspectives and needs varied considerably and the determinants of health for each respondent were too complex to be delineated into separable factors. However, for both married and divorced women with children, the family-centeredness of their experiences was

a significant factor mediating in all aspects of their health/wellbeing. They continued to perform all of their roles as wives, mothers, grandmothers, caregivers, and employees in their new host country and mobilized various skills to sustain the welfare and health/wellbeing of their families/themselves. Importantly, caregiving responsibilities and/or making the family ends meet were placed as a higher priority on women's lives rather than language training, pursuing education, and engaging in the labour market which limited various opportunities for all respondents with young children; however, it was also considered fulfilling and positively contributed to their wellbeing.

While gender was a central issue to understanding participants' health, it intersected with other determinants, which were deeply shaped by historical power relations that played out at structural levels. Moreover, these intersections resulted in within- group variations and complexity of women's lives. Therefore, focusing on one of the axes of discrimination, obscures the importance of other social markers. For instance, the age at the time of arrival as well as structural racism were both fundamental factors that intersected with finding jobs or continuing education—while we could not ignore the role of gender. As the result, the participants were very differently positioned socially and immigration was accompanied by both upward and downward social mobility that offered or constrained their access to social and material goods.

Language mastery was one of the determinants affecting all participants in some stage of their migration trajectory. It directly influenced health/wellbeing through creating stress and low self-esteem and was a pivotal challenge intersecting with other factors: pursuing further education, finding employment, access to health services, and navigating existing services; as well as isolation and rebuilding new ties.

The aging process was another important factor that resulted in some physical ailments, particularly for women residing in Canada for longer terms; however, it was not a prominent element in their explanation of health status decline. Meanwhile, it was considered as a positive factor enhancing the health/wellbeing of younger respondents. Equally important, age at immigration was played a pivotal role for respondents who immigrated later in their life and intersected with finding jobs, improving language proficiency, and continuing education. Notably, ageism as a reason for lower level career adjustment, as well as the fear of aging were other issues that were recounted. Although being afraid of aging might also attributed to the loss of extended family, social supports, and changing family structures in Canada.

Another determinant of health about which all participants agreed was the impact of social support networks on their health/wellbeing whether positively or negatively. Broadly speaking, the respondents experienced the loss of extended family supports. It is important to indicate that women tried to build new friendships and/or sought out work colleagues as the potential sources of social support networks to enhance their health/wellbeing. With respect to social networks, as a result of homophobic Iranian society, one of the participants felt losing her networks there, so she found Canada as a place of belonging where she was accepted and where she could build her own social networks. Therefore, immigration positively impacted her wellbeing.

Immigration offered new opportunities—such as education and/or employment—for four respondents, and they associated these factors with enhancing their health. On the other side, embedded in Canadian structural racism, most professional Iranian immigrant women faced barriers in recognition their credentials and in the conversion of their educational

attainment into economic earnings; therefore, they were often challenged with un/underemployment. Equally important, being trapped in menial positions forced them to confront the reality of insecure jobs and limited access to supplementary health benefits, as well as accepting unhealthy and abusive working conditions when keeping their positions was essential to their/their family survival. Furthermore, the discrepancy between their expectations of what life would be and the reality experiences after migration was also a source of stress.

Beyond structural racism, half of informants reported that they were unfairly targeted by the mainstream Canadian population, and that their experiences were fraught with personal racism. However, they found their own coping strategies to alleviate the generating stress.

Moreover, bureaucratic and economic barriers linked to sanctions, affected some participants' health through a variety of ways. First, the currency devaluation made it more difficult for them—particularly for low-income women who relied on the money transferred from Iran—to access to their basic needs. Second, sanctions forced Iranian government to turn to low-quality gasoline that makes some urban cities among the worst air-polluted in the world—among other factors; therefore, the fresh weather they found in Canada was another factor that boosted health and wellbeing of six participants. Third, barriers that curbed the importation of medicines and hospital equipment to Iran had been a concern for some; feeling more secure with regards to the quality of health care and health resources in their host country positively affected the health of two women. Fourth, sanctions made it more difficult for respondents to maintain their connections with relatives in Iran.

Taken together impacts of sanctions and unemployment/underemployment resulted in low income and poverty for four participants, which in turn affected transportation, leisure opportunities, housing, social networks, and affording the cost of medicine and other services that were not covered by provincial health care insurance.

Additionally, the geographic or spatial contexts including the physical distance for participants longing for travelling to Iran or being keen to host their families in Canada and also lack of transportation for access to health services make another layer of complexity to the factors that impact health/wellbeing.

The other factor that influenced the health/wellbeing of participants was housing. Home was a refuge for six women, a place to exert control and/or to enjoy its facilities, as well as a source of pride, prestige, and social class. On the other side, one respondent lived in a damp and mouldy house, and four had difficulty paying rent and/or for access to transportation.

With regard to health care, participants varied in their perceptions of health changes attributable to health services. Five participants reported that it had not affected their health, but seven indicated it had improved or worsened their health and wellbeing. Beyond the effect of sanctions as earlier discussed, coverage of the most hospital and physician costs was a factor that two respondents perceived brought them peace of mind and boosted their health. However, several issues, particularly early discharge from hospital, the cost of some services such as dental care, transportation/physical distance, lack of same-sex health care providers, discrimination, poor referral to specialists, language barriers, and distrust were reasons for frustration. Notably, the role of racialized status and gender—to mention a few—and their

intersections with the socioeconomic status after immigration and access to non-publicly funded health care services are neither trivial nor separable.

Moreover, prolonged economic insecurity, characteristics of the place of residence and neighbourhood, racist and disablist attitudes, and lack of affordable daycare—just to mention a few—all worked to build a disabling society that permanently damaged one of participants' health and wellbeing. Her right to employment was denied—while her gender intersected with racialized status, as well as invisible disability—which, consequently, accelerated her poverty.

To conclude, all respondents challenged with various stressors pre- and post-migration. While uprooting was associated with enormous difficulties and considerable socioeconomic hardship that deteriorate four women's health/wellbeing; immigration offered new opportunities and resources that resulted in maintaining or improving the health/wellbeing of the other two-thirds. Pursuing education, finding a meaningful job, upward mobility, leaving a homophobic and/or a hostile society, and better living standards/future for themselves/their children were all reasons that boosted or at least sustain the health/wellbeing of eight women. Importantly, as mentioned earlier the multiple intertwined determinants affected health/wellbeing of each participant. Therefore, almost all of respondents lost some resources and gained new opportunities. Each respondent's health outcomes shaped by their pre-migration experiences, as well as their everyday lives realities in the host country. For four participants, their gains were significantly outweighed the losses that enhanced their health, and for the other four the benefits and disadvantages of immigration were near equal, therefore, their health remained stable.

## **Recommendations**

The participants tried to fulfil their desires, interests, and potentials; however, such attempts also depended heavily on the efforts offered by social institutions to erase the fault lines of inequities in order to provide spaces for them to develop their capacities and better enable them to rebuild their new worlds. The evidence presented in this study demonstrates that women who were known as the members of an ethnicity group were extremely heterogeneous; therefore, their needs and concerns were widely different. Taking their stories into consideration, informants acknowledged the reasons that resulted in their positions in the society and while no single policy will work for all, there are some recommendations that might help to sustain or improve Iranian immigrant women:

- Providing an affordable childcare program to both alleviate the caregiving responsibilities and to enable women to participate in the language classes, pursuing further education, and engaging in the labour market
- Funding for post-secondary education in order to provide opportunities to boost university enrolment for women who face with financial barriers
- Investing in an affordable housing program, as well as establishing grocery stores and public fitness facilities in low-income neighbourhoods
- Improving labour market by taking action on the recognition of foreign credentials, as well as by providing an accessible environment for women with disabilities; while recognizing that overcoming the persistence of structural racism, sexism, and disablism in Canada has been still an ongoing challenge

- Increasing social assistance benefits for low-income women, as well as considering the socio-cultural stigmas
- Enhancing availability of supplementary health plans for part-time employees and women with disabilities
- Providing information about available services in Farsi language to facilitate navigation of confusing service systems
- Strengthening government-supported access to language training to offer longer and more extensive programs
- Expanding community intervention programs such as music and dance classes, poetry readings, and celebration of both Iranian and Canadian holidays in order to make a sense of belonging and provide an insight into the host culture

## **Limitations**

The experiences of Iranian immigrant women will not aimed to generalize the diversity of immigrant women in Canada; however, the experiences of the respondents of this study have also demonstrated a significant variant between them as a subgroup. Based on the findings from this study, number of limitations have been identified: first, the sample of the research was small; second, most participants were in their middle age—however, I tried to ensure the diversity in marital status, length of residence, and immigration class—and third, the study was conducted in a mid-sized city with non-significant level of community cohesion. Therefore, to advance the findings, further researches are required to examine the reality experiences of a broader Iranian immigrant women.

Despite the limitations, the findings of this exploratory research are significant. While social determinants of health approach expands my thoughts from “the cell to social”, an anti-oppression critical perspective enriches my understanding of how these social factors operate, and an intersectionality as my theoretical framework offers me a nuance way to navigate the complex intertwined and integrated factors that shape health and wellbeing. Therefore, this thesis contributes to the existing literature by focusing on the impact of immigration on the wellbeing of Iranian immigrant women particularly by using an intersectional approach. Additionally, the future of Canada as a healthy society depends on the wellbeing of immigrants as a significant component of its population; accordingly, the actions to eliminate the structural roots of health inequities can benefit Canada as a whole. Moreover, Ottawa as the capital of Canada has been host to many Iranians but there was an apparent lack of studies about Iranian immigrant women in this city. More importantly, as a key component of feminist health approach; enhancing the voices and visibility of participants was a way for empowering.

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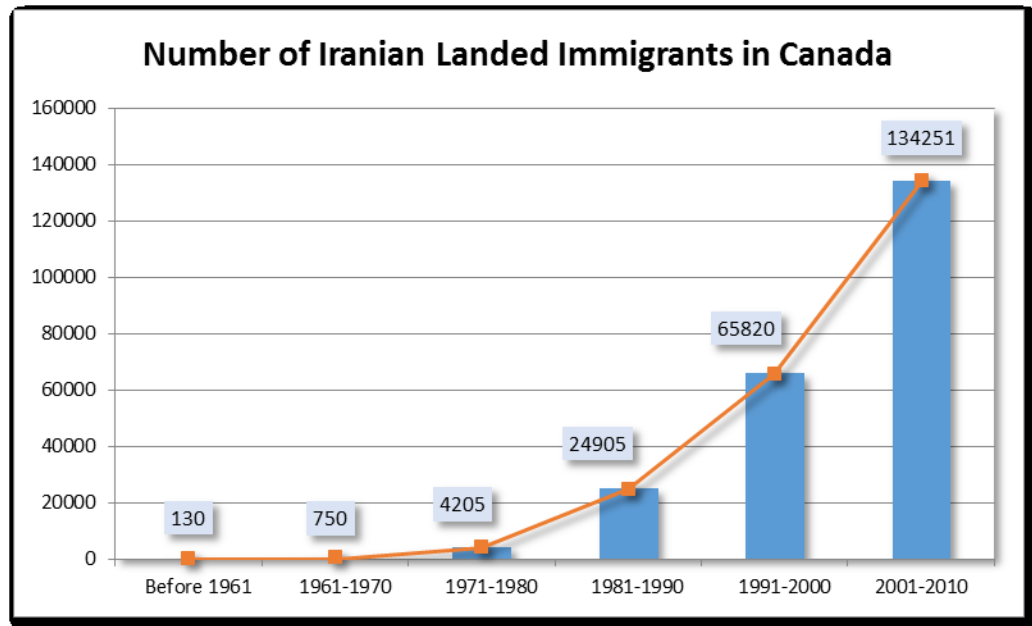
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# Appendices

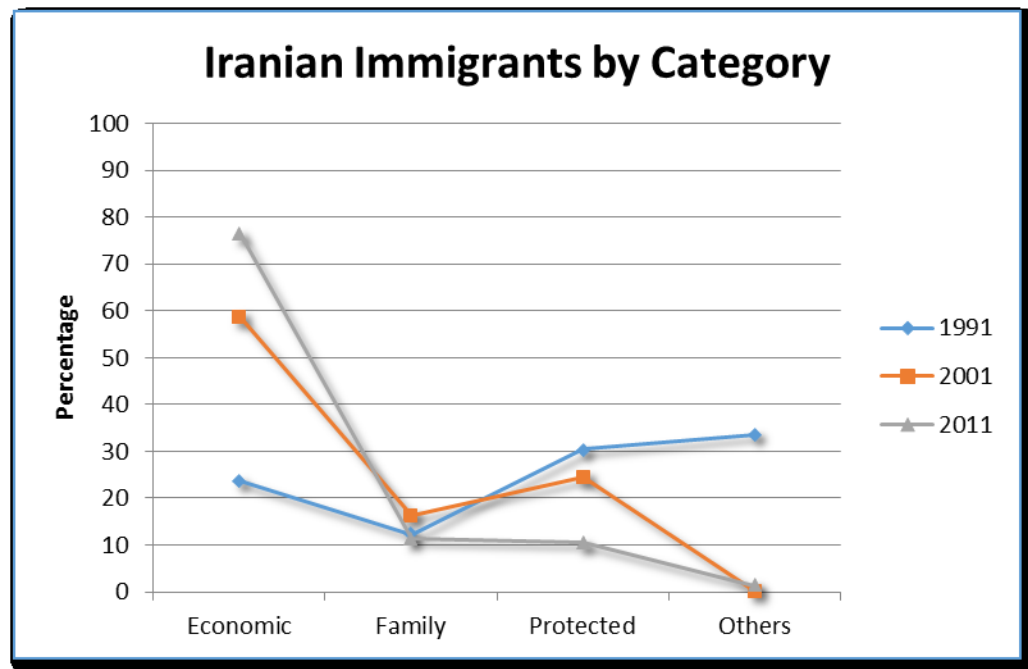
Appendix 1: Number of Iranian Landed Immigrants in Canada



Adapted from Statistics Canada, 2007 & Chagnon, 2013

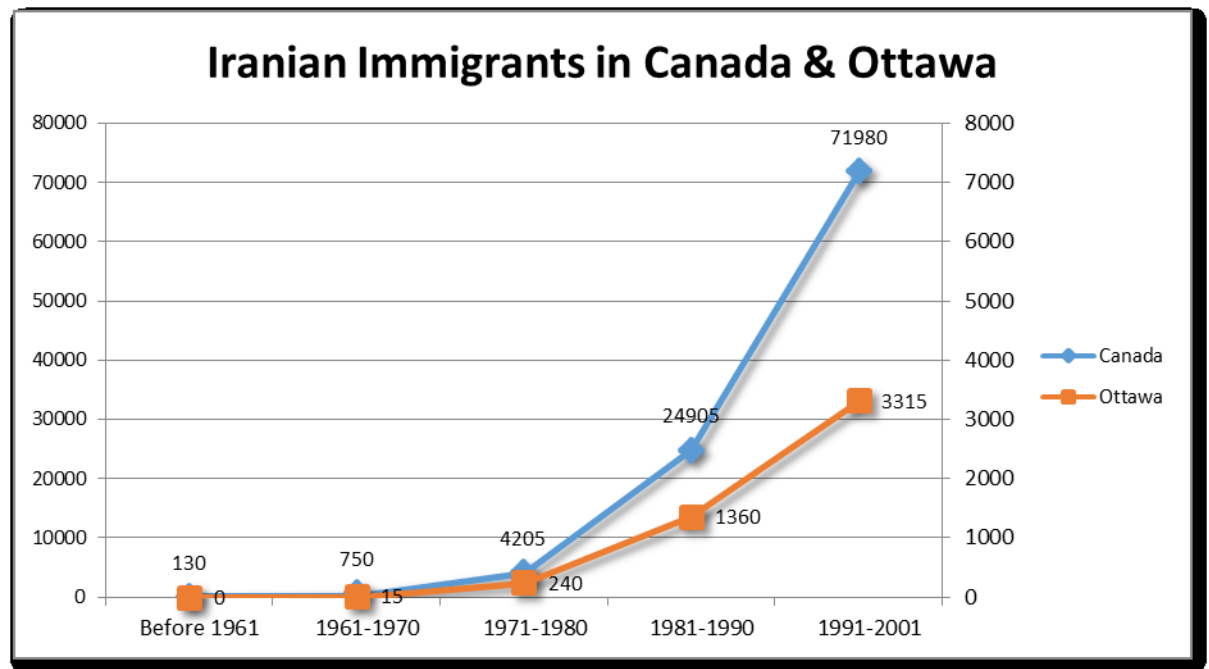
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## Appendix 2: Iranian Immigrants by Category



Adapted from Chagnon, 2013

### Appendix 3: Iranian Immigrants in Canada & Ottawa



Adapted from Statistics Canada, 2007

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## Appendix 4: Interview Guide

### Interview Guide

1. What does health/wellbeing mean to you?
2. How do you feel about your health status?
3. How do you feel about your health/wellbeing before moving to Canada?
4. Could you describe your overall health/well-being since you have come to Canada?
5. What do you think most affects your health since coming to Canada?
6. How and why do you think these issues impact your health?
  - a. Probes if these issues do not come up:
    - i. What is your opinion about the relation between physical environment and weather, and Health/wellbeing?
    - ii. What is your opinion about the relation between personal health practices (diet, smoking, and exercise) and Health/wellbeing?
    - iii. What do you think about employment/working condition?
    - iv. What is your idea about the effect of income on the health?
    - v. What about language proficiency?
7. Does your gender influence your health/wellbeing? If so, how?
8. Do you think discrimination and racism affect health/wellbeing? If so, how?
9. Do you think age affects health/wellbeing? If so, how does it affect yours?
10. What do you think about the roles of social support networks, worry about family here and at home, and health/wellbeing?
11. What is your opinion about the relation between health care services and health/wellbeing?
12. Could you tell me about your experiences with health care services in Canada?

- 
13. What is your opinion about 3 months waiting period before getting your health card?
14. Could you tell me how do you know about preventive programs such as Pap smear?
- What are your experiences in Canada?
15. What about your oral health?
16. How do you feel about your health care needs and health care providers?
17. What do you think could be done to improve knowledge of health resources and access to services for Iranian newcomers?
18. What have you done for boosting your health/wellbeing?
19. Is there anything else about Health and wellbeing you would like to share with me?

## Appendix 5: Ethics Approval

**File Number:** 09-13-06

**Date (mm/dd/yyyy):** 10/15/2013



**Université d'Ottawa**  
Bureau d'éthique et d'intégrité de la recherche

**University of Ottawa**  
Office of Research Ethics and Integrity

### Ethics Approval Notice

#### Social Science and Humanities REB

**Principal Investigator / Supervisor / Co-investigator(s) / Student(s)**

| <u>First Name</u> | <u>Last Name</u> | <u>Affiliation</u>                | <u>Role</u>        |
|-------------------|------------------|-----------------------------------|--------------------|
| Derise            | Spitzer          | Social Sciences / Women's Studies | Supervisor         |
| Nasim             | Khatibsehnari    | Social Sciences / Women's Studies | Student Researcher |

**File Number:** 09-13-06

**Type of Project:** Master's Thesis

**Title:** The impact of immigration on the health and wellbeing of Iranian immigrant women: Voices from Ottawa/Gatineau

| <b>Approval Date (mm/dd/yyyy)</b> | <b>Expiry Date (mm/dd/yyyy)</b> | <b>Approval Type</b> |
|-----------------------------------|---------------------------------|----------------------|
| 10/15/2013                        | 10/14/2014                      | Ia                   |

**(Ia: Approval, Ib: Approval for initial stage only)**

**Special Conditions / Comments:**  
N/A



**Université d'Ottawa**

Bureau d'éthique et d'intégrité de la recherche

**University of Ottawa**

Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at: <http://www.research.uottawa.ca/ethics/forms.html>.

Please submit an annual status report to the Protocol Officer four weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at: <http://www.research.uottawa.ca/ethics/forms.html>.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: [ethics@uOttawa.ca](mailto:ethics@uOttawa.ca).

**Signature:**

Riana Marcotte  
Protocol Officer for Ethics in Research  
For Barbara Graves, Chair of the Social Sciences and Humanities REB

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## Appendix 6: Recruitment Flyer

Your participation in a research study is needed!

Are you an Iranian woman?

Have you been living in Ottawa/Gatineau area?

Did you come to Canada as an immigrant (permanent resident- family class, economic immigrant, or refugee)?

Are you over 18 years of age?

And willing to talk?

If so, I would like to hear from you!

My name is Nasim Khatibsemnani and I am an International medical Graduate (IMG) who has worked more than 15 years in the Middle East as a physician and is currently a Master student in the University of Ottawa. My research aims to explore the impact of immigration on the health and wellbeing of Iranian immigrant women who reside in Ottawa/Gatineau.

I am interested in learning about your experiences and perspectives about health/wellbeing. There are no right or wrong answers, just your perspectives. Your participation is voluntary and can be conducted in Persian (Farsi) or English. Your participation will consist of 60-90 minutes in an individual interview in one or two sessions and 1-2 hours in a discussion group which consists of 4-6 Iranian immigrant women in one or two sessions. Eligible participants will be selected on a first come/first served basis. The information you provide may contribute in improving the health and wellbeing of Iranian-Canadian women.

For more information and/to participate in the study please contact:

Nasim Khatibsemnani

Master's student, Institute of Women's studies, University of Ottawa

Tel: [REDACTED]

Email: [REDACTED]

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## Appendix 7: Consent Form



### Consent Form-Interview

The Impact of Immigration on the Health and Wellbeing of Iranian Immigrant Women:  
Voices from Ottawa/Gatineau

#### Research Team:

Principal Investigator: Nasim Khatibsemnani

Faculty of Social Sciences, Institute of Women's Studies, University of Ottawa.

Tel:

Email:

Thesis Supervisor: Dr. Denise L. Spitzer.

Canada Research Chair, Gender, Migration and Health, Faculty of Social Sciences, Institute of Women's Studies, University of Ottawa.

Tel:

Email:

#### Invitation to Participate:

I am invited to participate in a study entitled "The Impact of Immigration on the Health and Wellbeing of Iranian Immigrant Women: Voices from Ottawa/Gatineau" conducted by Nasim Khatibsemnani.

#### Purpose of the Study:

The purpose of this study is to explore the impact of immigration on the health and wellbeing of Iranian women residing in Ottawa/Gatineau, their needs, concerns, and the factors that influence their wellbeing.

#### Participation:

My participation will consist essentially of 60-90 minutes in an individual interview in one or two sessions at a location of my choice at a time of convenient for me. I have been told that there are no right or wrong answers; just my opinion. I will be asked to answer to a brief personal data questionnaire that will take about 5 minutes to complete. During the interview, the researcher

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may take notes for herself. The interview will be audio-recorded to ensure accuracy and to provide an opportunity for the interviewer to listen to its content later on; however, I have the option to ask her not to audio-record the interview. Moreover, I will have the opportunity to review the interview transcripts and give my feedback.

Risks:

I understand that my participation in this study will necessitate that I share some personal information and talk about some issues that can be distressing; however, I have received assurance from the researcher that every effort will be made to minimize these risks. Therefore, I can ask questions, stop the interview, change topics, take a break, decline to answer any question or continue the conversation – the decision is mine.

Benefits:

My participation in this study is important. I will help the researcher to learn more about the impact of immigration on the health and wellbeing of Iranian immigrant women in Canada. As the result of which, she might be able to influence policies and programmes for Iranian immigrant women and their families. Better health and wellbeing of Iranian immigrant women will also benefit Canadian society as a whole. In addition, the researcher will provide some information about local resources that may be of use to me or others I know. At the completion of the research, I will also receive a summary of the research results with an invitation to provide feedback.

Confidentiality and Anonymity:

I have received assurance from the researcher that the information I will share remain strictly confidential, and my confidentiality will be protected. I understand that the contents for this study will be used by the researcher as partial fulfillment of the requirements for the Master of Arts in Women's Studies. Information gathered in this research study may be published or presented in public forums; however, my name or other identifying information will not be used or revealed. The researcher has signed oaths of confidentiality committing herself to uphold the anonymity and confidentiality of all statements and she will use a false name to remove identifiers and only she will have access to it. She will use this name in any public presentation, written or oral, of this project and she may change some details of my story so that I will not be personally recognized in any public presentation of the research.

Conservation of Data:

All sources of data, such as written records, electronic data, audio recordings, and transcripts will be kept in a secure manner (locked office) and they will be put in a locked filing cabinet separately from consent form and demographic information in the office of researcher's supervisor at the University of Ottawa where only researcher will have access to them. For technical safeguards, the researcher will use a password for her computer and also protect it by an anti-virus. All data will be conserved in a safe place for 5 years and the starting time of the conservation period will begin after completion of the project.

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Voluntary Participation:

I am under no obligation to participate and if I choose to participate, I may withdraw from the study at any time and/or refuse to answer any questions. In the case I choose to withdraw, the researcher will only use the information I have given her with my permission. If I do not wish her to use this information, she will destroy it or give it back to me.

I, -----, agree to participate in the above research conducted by Nasim Khatibsemnani of the Faculty of Social Sciences, Institute of Women's Studies, whose research is under the supervision of Dr. Denise L. Spitzer. I understand that by accepting to participate I am in no way waiving my right to withdraw from the study.

I agree to audio-record the interview ☐

I do not agree to audio-record the interview ☐

If I have any questions about the study, I may contact the researcher or her supervisor. If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research. University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5

Tel: (613)562-5387

Email: [ethics@uottawa.ca](mailto:ethics@uottawa.ca)

There are two copies of the consent form, one of which is mine to keep.

Participant's Signature

Date

Researcher's Signature

Date

---

## Appendix 8: Personal Data Questionnaire

### Personal Data Questionnaire

Date of birth (dd/mm/yyyy):            /        /19

How many years have you been living in Canada?

Education:

- ☐ University/college graduate
- ☐ Some university/college degree
- ☐ High school graduate
- ☐ Some high school education
- ☐ Less than high school education

Employment:

- ☐ What was your job in Iran?
- ☐ If you had a job, did you work?
  - ☐ Part-time
  - ☐ Full-time
- ☐ What is your job in Canada?
- ☐ If you are working, do you work?
  - ☐ Part-time
  - ☐ Full-time

Total Household Income:

- 
- |                                           |                                           |
|-------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Less than 10,000 | <input type="checkbox"/> 50,001-60,000    |
| <input type="checkbox"/> 10,000-20,000    | <input type="checkbox"/> 60,001-70,000    |
| <input type="checkbox"/> 20,001-30,000    | <input type="checkbox"/> 70,001-80,000    |
| <input type="checkbox"/> 30,001-40,000    | <input type="checkbox"/> More than 80,001 |
| <input type="checkbox"/> 40,001-50,000    |                                           |

Immigrant Category:

- ☐ Family Class
- ☐ Economic Immigrants
- ☐ Refugees
- ☐ Refugee claimant

Marital Status:

- |                                   |                                     |
|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Single   | <input type="checkbox"/> Widowed    |
| <input type="checkbox"/> Married  | <input type="checkbox"/> Common-law |
| <input type="checkbox"/> Divorced |                                     |

Do you have children? If so, how many? How old are they?

## Appendix 9: Demography of the Participants

| Name           | Age Group | Immigration Status | Length of Residence in Canada | Place of Residence | Education Attainment               | Employment Status in Iran | Employment Status in Canada | Marital Status | Number of Children |
|----------------|-----------|--------------------|-------------------------------|--------------------|------------------------------------|---------------------------|-----------------------------|----------------|--------------------|
| <b>Touran</b>  | 60-70     | Refugee            | 25                            | Ottawa             | University/Colleague Graduate      | Full Time                 | Part Time                   | Divorced       | 3                  |
| <b>Arezoo</b>  | 50-60     | Refugee            | 1                             | Ottawa             | Some University/Colleague Graduate | Part Time                 | Unemployed                  | Divorced       | 2                  |
| <b>Jawaher</b> | 60-70     | Family Class       | 3                             | Gatineau           | University/Colleague Graduate      | Full Time                 | Unemployed                  | Married        | 2                  |
| <b>Sahar</b>   | 50-60     | Refugee            | 13                            | Ottawa             | High School Graduate               | Full Time                 | Full Time                   | Married        | 2                  |
| <b>Mahtab</b>  | 50-60     | Family Class       | 22                            | Ottawa             | Some University/Colleague Graduate | Part Time                 | Full Time                   | Common -Low    | 3                  |
| <b>Roya</b>    | 50-60     | Refugee            | 25                            | Ottawa             | University/Colleague Graduate      | Full Time                 | Unemployed                  | Divorced       | 2                  |
| <b>Bahar</b>   | 30-40     | Economic Class     | 11                            | Gatineau           | University/Colleague Graduate      | Part Time                 | Full Time                   | Single         | 0                  |
| <b>Roz</b>     | 50-60     | Family Class       | 24                            | Ottawa             | Some University/Colleague Graduate | Unemployed                | Part Time                   | Married        | 2                  |
| <b>Azadeh</b>  | 30-40     | Family Class       | 2                             | Ottawa             | University/Colleague Graduate      | Full Time                 | Part Time                   | Married        | 0                  |
| <b>Atousa</b>  | 60-70     | Economic Class     | 5                             | Gatineau           | University/Colleague Graduate      | Full Time                 | Unemployed                  | Single         | 0                  |
| <b>Parisa</b>  | 60-70     | Economic Class     | 6                             | Ottawa             | University/Colleague Graduate      | Full Time                 | Part Time                   | Single         | 0                  |
| <b>Mina</b>    | 50-60     | Economic Class     | 3                             | Ottawa             | University/Colleague Graduate      | Full Time                 | Part Time                   | Married        | 2                  |

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Appendix 10: Impact of Immigration on Health: Improvement, Deterioration, or Unaffected

| <b>Name</b>    | <b>Immigration Status</b> | <b>Length of Residence</b> | <b>Health Status Change</b>   |
|----------------|---------------------------|----------------------------|-------------------------------|
| <b>Touran</b>  | Refugee                   | Long-term                  | Strongly Improve              |
| <b>Arezoo</b>  | Refugee                   | Recent                     | Decline                       |
| <b>Jawaher</b> | Family Class              | Recent                     | Same                          |
| <b>Sahar</b>   | Refugee                   | Mid-term                   | Same (Minor Trend to Decline) |
| <b>Mahtab</b>  | Family Class              | Long-term                  | Decline                       |
| <b>Roya</b>    | Refugee                   | Long-term                  | Decline                       |
| <b>Bahar</b>   | Economic Class            | Mid-term                   | Strongly Improve              |
| <b>Roz</b>     | Family Class              | Long-term                  | Same                          |
| <b>Azadeh</b>  | Family Class              | Recent                     | Improve (Minor Trend)         |
| <b>Atousa</b>  | Economic Class            | Mid-term                   | Same                          |
| <b>Parisa</b>  | Economic Class            | Mid-term                   | Decline                       |
| <b>Mina</b>    | Economic Class            | Recent                     | Strongly Improve              |