Original Article

Challenges of Iranian Migrant Nurses: A Qualitative Insight into their Experiences Abroad

Farinaz Moghaddasi[1], Ali Akbar Fazaeli[1], Maryam Zahmatkesh[2], Abbas Ebadi[3], Ali Mohammad Mosadeghrad[1]

[1]Department of Health Management, Policy, and Economics, Faculty of Health, Tehran University of Medical Sciences, Tehran, Iran, [2]School of Business and Management, Royal Holloway University of London, London, UK, [3]Nursing Care Research Center, Clinical Science Institute, Baqiyatallah University of Medical Sciences, Tehran, Iran

Abstract

Background: In recent years, the migration of Iranian nurses has significantly increased. They are faced with various professional and social challenges during their transition. This study explored these challenges faced by Iranian migrant nurses in three primary destination countries: Germany, Denmark, and Australia. **Materials and Methods:** This study employed a descriptive phenomenological approach to explore the lived experiences of 20 Iranian migrant nurses (8 in Australia, 8 in Denmark, and 4 in Germany). Data were collected via semi-structured, audio-recorded online interviews conducted between April and August 2024. Each interview lasted approximately 45 minutes. Data were analyzed using Colaizzi's method, supported by MAXQDA software. **Results:** Analysis revealed four main themes reflecting complex challenges faced by Iranian migrant nurses: Professional Transition Challenges, Economic Vulnerability, and Cultural and Social Dislocation. Professional Transition Challenges included unrecognized prior qualifications, diminished professional competencies, limited opportunities for advancement, and language-related difficulties in professional and clinical communication. Economic Vulnerability involved financial strain due to high living costs and economic instability, substantial expenses related to visas and exams, and negative impact of currency fluctuations. Cultural and Social Dislocation was marked by difficulties in cultural adaptation, value conflicts, experiences of discrimination, and strained interactions. Psychological and Emotional Strain included persistent loneliness, homesickness, anxiety, and identity disruption. **Conclusions:** The findings highlight the complex challenges faced by Iranian migrant nurses and emphasize the need for targeted support policies in host countries. Addressing issues like ethical recruitment, financial support, and language training can facilitate their integration and improve healthcare outcomes in host countries.

Keywords: *Cultural integration, emigrants and immigrants, Iran, nurses, occupational stress*

Introduction

Nurse migration has emerged as a significant and rapidly expanding phenomenon in the early 21st century. It is increasingly being regarded as a "global crisis."[1] Factors such as aging populations, declining birth rates, the shift from acute to chronic illnesses, and rising professional demands have led to a growing need for healthcare professionals in high- and upper-middle-income countries.[2] However, the global supply of nurses has failed to keep pace with this increasing demand.[3] Projections estimate a global shortfall of 7.6 million nurses by 2030, a figure that does not account for the additional strain caused by the COVID-19 pandemic.[4] One major response to this shortage has been the international recruitment of nurses from low- and middle-income countries to fill healthcare gaps in wealthier nations.[5] Today, one in eight qualified nurses globally works in a country different from where they were trained or born.[6] Among these, Iranian nurses have become increasingly sought after due to their advanced education and clinical competence. Many migrate to countries such as Australia, Germany, and Denmark.[6] Although there are no precise statistics on Iranian nurse migration, anecdotal evidence and recent surveys suggest a substantial increase in migration, especially during and after the COVID-19 crisis.[6-8]

Iran itself faces a critical nursing shortage. With only 1.5 nurses per 1000 people, compared to more than 18 per 1000 in some high-income countries, Iran is estimated to need over 100,000 additional nurses.[9] This domestic shortage, combined

How to cite this article: Moghaddasi F, Fazaeli AA, Zahmatkesh M, Ebadi A, Mosaddeghrad AM. Challenges of Iranian migrant nurses: A qualitative insight into their experiences abroad. Iran J Nurs Midwifery Res 2026;31:310-21.

Submitted: 24-Dec-2024. **Revised:** 10-Aug-2025. **Accepted:** 16-Aug-2025. **Published:** 07-May-2026.

Address for correspondence:
Prof. Ali Mohammad Mosaddeghrad, Department of Health Management, Policy, and Economics, Faculty of Health, Tehran University of Medical Sciences, Tehran, Iran.
E-mail: mosadeghrad@yahoo.com

Access this article online

Website: https://journals.lww.com/jnmr

DOI: 10.4103/ijnmr.ijnmr_445_24

Quick Response Code:

with improved migration policies abroad, has further incentivized Iranian nurses to seek employment overseas. Several destination countries have simplified recruitment procedures and relaxed immigration rules in response to their own healthcare needs.[6] For example, Germany has amended its immigration policies to facilitate the entry of international healthcare professionals.[10,11] It is projected to need around 520,000 new nurses by 2030.[12] Denmark, too, has begun actively recruiting nurses from outside the EU.[13] In Australia, nurse shortages are expected to reach 85,000 by 2025 and 123,000 by 2030.[14]

These dynamics have increased the appeal of migration among Iranian nurses, who seek better professional opportunities and improved living conditions. Yet, the migration process often brings with it significant emotional, cultural, and professional challenges. Migrant nurses must navigate new healthcare systems, languages, and social environments, making integration difficult and, at times, overwhelming. One promising way to address these issues is through studying the lived experiences of migrant nurses. While existing research has examined the motivations behind Iranian nurse migration, there is a notable lack of focus on the challenges they face after relocation. Therefore, the aim of this study was to qualitatively articulate the challenges faced by Iranian migrant nurses abroad. Specifically, this research focuses on the experiences of these nurses in Germany, Denmark, and Australia. The findings of this research will offer valuable insights for policymakers in both the countries of origin and the host nations, as well as for nurses considering migration. Additionally, the outcomes will contribute to enhancing the cultural, social, and professional integration of Iranian nurses, minimizing their negative experiences, and providing strategies to overcome the challenges they encounter.

Materials and Methods

This study employed a descriptive phenomenological approach to identify and describe the challenges faced by Iranian migrant nurses in the process of migration, while exploring their lived experiences of these challenges. Descriptive phenomenology, founded by Edmund Husserl, is a qualitative research method that focuses on the exploration and description of phenomena. In this approach, the researcher aims to understand experiences as individuals have felt them, without any judgment or personal interpretation interfering in the process. The primary goal of descriptive phenomenology is to identify the structure or essence of a lived experience in order to accurately describe its true meaning.[15]

Sampling in this study was, first, conducted purposefully and, subsequently, using a snowball sampling method. A total of 20 Iranian migrant nurses were selected, including 8 who migrated to Denmark, 8 to Australia, and 4 to Germany. This selection provided geographical and cultural diversity within the sample, enabling the collection of a wide range of experiences related to migration and its challenges. Data were collected through semi-structured interviews with 20 migrant nurses. These interviews were conducted online and in audio format using various platforms such as Telegram, WhatsApp, Google Meet, and Skype from April to August 2024. The interview questions were designed based on the research objectives and prior studies. The average duration of each interview was approximately 45 minutes, with a range of 30 to 60 minutes. The semi-structured format provided us with the necessary flexibility to conduct a deeper exploration of the participants' experiences while maintaining a general framework for the interviews.

In the present study, data analysis was performed using Colaizzi's method, chosen for its focus on describing the lived experiences and the meanings as expressed by participants, particularly regarding migration challenges. This approach enables the researcher to present participants' experiences accurately, emphasizing their direct descriptions without imposing personal interpretations.[16] The analysis was conducted using MAXQDA Analytics Pro, version 2020 (VERBI GmbH, Berlin, Germany). The Colaizzi method involves the following steps: (1) Familiarization with the data: the first author listened to all recorded interviews several times and transcribed them verbatim and then read the transcripts repeatedly to immerse herself in the data and gain a general sense of the participants' experiences; (2) Extracting significant statements: the researcher reviewed the transcripts and extracted key statements directly related to the phenomenon under study, highlighting them and noting their context; (3) Formulating meanings: each significant statement was carefully rephrased into short conceptual meanings; (4) Organization into themes: the formulated meanings were grouped into categories and clustered into themes; (5) Exhaustive description: a detailed description of the phenomenon was developed by combining the identified themes; (6) Fundamental structure: the essential structure of the lived experience was synthesized from the exhaustive description; and (7) Validation: a summary of the findings was returned to several participants for member checking, and their feedback was incorporated where relevant.[16] This analytical approach enabled an in-depth understanding of Iranian nurses' migration experiences by staying close to their narrated realities. Throughout the process, we aimed to ensure fairness, transparency, and fidelity to the participants' authentic voices.

To ensure the trustworthiness of the study, several strategies were applied based on Lincoln and Guba's criteria. Credibility was enhanced through purposive and snowball sampling to ensure a wide range of lived experiences. Member checking was conducted by returning the summarized descriptions of the findings to several participants for confirmation of accuracy.

Moreover, dependability was supported by repeated reading and consistent handling of the data. Confirmability was maintained through transparent documentation of all research steps. Finally, transferability was strengthened by providing rich and detailed descriptions of the context, participants, and data collection process.

Ethical considerations

This study forms part of a Ph.D. thesis in health economics entitled "Calculating the Financial Burden of Nurses' Migration: Causes and Solutions for Mitigation." It has received approval from the Ethics Committee of Tehran University of Medical Sciences (Ethics No. IR.TUMS.SPH.REC.14010289). All ethical considerations were observed, including obtaining informed consent from participants, ensuring their freedom to participate or withdraw from the interviews, securing permission to record audio, maintaining the confidentiality of personal information, and ensuring that the researcher's personal opinions did not interfere with the stages of data collection, analysis, or reporting.

Results

The demographic data of the interviewees are presented in Table 1. Most of the participants were women (17 individuals), married (14 individuals), and aged between 31 and 40 years (9 individuals). The majority held a bachelor's degree (13 individuals) and had over 5 years of work experience (15 individuals). Moreover, eight participants had migrated to Australia, eight to Denmark, and four to Germany.

Participants identified the challenges they faced after migrating from Iran, which were categorized into four main themes: Professional Transition Challenges, Economic Vulnerability, Cultural and Social Dislocation, and Psychological and Emotional Strain. These challenges are presented in detail in Table 2, where they are organized into themes and subthemes.

Professional transition challenges

This theme captures the core challenges migrant nurses face during their professional transition and the gradual shifts in their professional identity. These disruptions mainly arise from three interconnected factors: lack of recognition of prior professional qualifications, erosion of professional competencies and limited opportunities for career advancement, and language-related challenges in professional and clinical communication. Together, these contribute to professional instability, self-doubt about clinical abilities, and an ongoing struggle to redefine one's role within host countries' healthcare systems.

Participants frequently reported difficulty re-entering the nursing workforce, primarily due to the lack of automatic recognition of their educational and professional credentials. Many were required to undergo complex, lengthy assessment processes and pass language proficiency tests to regain eligibility for clinical practice, regardless of their extensive experience. These delays disrupted their career trajectories and undermined professional confidence.

The lived experiences suggest that expectations of professional migration, particularly to Denmark, often conflicted with structural realities. Many arrived with valid 3-year work visas expecting immediate employment but faced systemic barriers challenging their professional

Table 1: Demographic characteristics of participants

Participant ID	Gender	Age (year)	Marital Status	Educational Level	Work Experience in Iran	Destination Country
P1	Female	43	Married	Master's degree	21	Germany
P2	Female	27	Single	Master's degree	4	Germany
P3	Female	28	Married	Bachelor's degree	5	Germany
P4	Male	40	Single	Bachelor's degree	15	Germany
P5	Female	32	Single	Bachelor's degree	4	Australia
P6	Female	37	Married	Master's degree	11	Australia
P7	Female	38	Married	Bachelor's degree	7	Australia
P8	Female	27	Single	Bachelor's degree	4	Australia
P9	Female	27	Single	Master's degree	5	Australia
P10	Female	35	Married	Bachelor's degree	12	Australia
P11	Female	37	Married	Master's degree	10	Australia
P12	Female	32	Married	Master's degree	9	Australia
P13	Female	50	Married	Bachelor's degree	26	Denmark
P14	Female	42	Married	Bachelor's degree	20	Denmark
P15	Female	37	Divorced	Bachelor's degree	13	Denmark
P16	Female	50	Married	Bachelor's degree	23	Denmark
P17	Female	46	Married	Bachelor's degree	19	Denmark
P18	Female	37	Married	Bachelor's degree	12	Denmark
P19	Male	45	Married	Bachelor's degree	20	Denmark
P20	Male	42	Married	Master's degree	11	Denmark

Table 2: Main themes and subthemes of challenges faced by migrant nurses

Main Themes	Subthemes
Professional Transition Challenges	Lack of recognition of prior professional qualifications
	Erosion of professional competencies and limited opportunities for career advancement
	Language-related challenges in professional and clinical communication
Economic Vulnerability	Financial strain due to high living costs and economic instability
	Significant expenses related to visa procedures, exams, and migration
	Negative impact of currency fluctuations on financial stability
Cultural and Social Dislocation	Difficulty adapting culturally and value conflicts with the host society
	Experiences of discrimination, racism, or social exclusion
	Challenges in daily social interactions
Psychological and Emotional Strain	Chronic feelings of loneliness and emotional detachment
	Homesickness, grief, and anxiety related to separation
	Identity crisis and psychological disorientation

identity assumptions. The following quotations illustrate this: *"I sought assistance from one of the migration agencies, which exploited me and charged exorbitant fees. They falsely assured us that we would receive a work permit, but upon arrival in Denmark, we learned that we did not have one. I worked in a grocery store for over a year, doing hourly shifts just to make ends meet. I had to accept jobs I had never done before, and it was extremely challenging. Eventually, I passed the nursing exams here and finally secured a position in a hospital"* (P20).

"Three months after I arrived in Denmark, I began working. However, initially, I had to take a position in a care home, because I did not possess a work permit. Given my lack of the required permit, I accepted this job. I worked 20 hours a week, but it was very demanding and exhausting, and I felt dissatisfied from the outset" (P14).

Several participants mentioned the mandatory 6-month professional assessment course, usually conducted in hospital settings, which is crucial for final qualification recognition. They emphasized that securing an employer willing to support participation in this course is solely the individual's responsibility, rendering the job search complex and uncertain. Furthermore, even after successfully completing the course, permanent employment is not guaranteed, leaving many unsure about their long-term professional integration. One participant described the process as: *"Nurses migrating to Denmark must find an employer on their own, which is challenging. I was unemployed for over a year. I have been participating in the 6-month assessment course in the NICU of a hospital for about 3 months now. I emailed head nurses more than 20 times before 1 of them finally accepted me. It remains uncertain whether they will employ me after the 6-month period"* (P18).

Participants migrating with 3-year visas reported significant pressure due to strict deadlines imposed for completing professional registration and securing employment. Passing the registry exam within this limited timeframe was a major professional hurdle affecting their legal eligibility to practice nursing. Failure or delays could result in the loss of their legal status and force them to return to their home country, disrupting their career plans and integration. As one participant explained: *"My visa is valid for 3 years. If I cannot register within this timeframe, I will have to return to Iran. This is very stressful for me. My children are attending school here. If we return to Iran, they will be 3 years behind their peers"* (P17).

Moreover, the competitive job market intensified these challenges. Migrants had to navigate language exams and mandatory training courses while competing for a limited number of nursing positions. This environment created professional stress and uncertainty regarding job security and career progression. One participant noted: *"Here, you must take the Danish language exam and, then, complete a 6-month course in a hospital. The employer must approve you, only then are you permitted to work as a nurse in this country. This has led to Iranian migrants competing against one another. Everyone is stressed because there are many nurses but not enough jobs for them. Those who are authorized often face envy from other migrants"* (P13).

Additionally, migrant nurses frequently face ongoing demands to validate their competencies and improve language proficiency, requirements that often lead to frustration and emotional fatigue. In this regard, participants stated: *"In Denmark, you must consistently improve your skill level. When you email head nurses for job openings, they often do not even bother to open your message. The Danish government claims that a level 2 language skill is sufficient; however, when you apply for a job, they expect you to possess a level 7"* (P15).

"As a nurse, you must speak Danish fluently, or you cannot enter the job market. The migration process to Denmark is relatively smooth, but securing a job is exceedingly difficult. Many assert that Denmark does not have language requirements, but this is entirely false. You must study Danish for 2-3 years, starting from the basics. Patients here expect you to address all their problems comprehensively. Therefore, your language skills must be exceptional" (P16).

Many migrant nurses reported that although they had studied the destination country's language before migration, they encountered unexpected challenges upon arrival, especially due to regional dialects and specialized clinical vocabulary. These linguistic barriers hindered their full participation

in clinical discussions and effective communication with patients and colleagues. Such challenges increased stress, reduced confidence, and caused feelings of professional inadequacy. This issue was especially notable among migrants to non-English-speaking countries such as Germany and Denmark. Nurses explained that even when they understood native speakers, they often needed extra time to process information and respond, which limited their timely contributions to professional conversations. Participant quotes in this regard include: *"Although I had studied German for 4 years, when I arrived in Germany, I encountered difficulties with the language. Their accent was very different. In Iran, I was very active in the hospital and contributed during rounds but here, by the time I understand what is being said and formulate my response in my mind, the discussion has already ended"* (P3).

"The language here (Denmark) is extremely difficult. I have been working as a nurse in the hospital for 3 months, but during shift handovers, I sometimes forget my native language due to stress" (P18).

"*Language is my primary challenge. In Iran, I thought my language skills were sufficient, but when I came here (Australia), I could not speak with the local accent. For example, in the hospital, I am afraid to answer the phone because I do not understand what they are saying. This has made me feel less confident and like an outsider"* (P8).

"The language is a huge problem. My English is good, but patients here, even though they know English, refuse to speak with me in English. You have to speak Danish with them" (P14).

Another significant challenge reported by participants was deskilling, primarily linked to differences in care standards and role expectations between Iran and host countries. Despite holding academic degrees and considerable clinical experience, many Iranian nurses were assigned tasks similar to nursing assistants. This limited their ability to apply their full range of skills and competencies. Consequently, many of them experienced frustration, disappointment, and a loss of professional identity. Participants reported these challenges as follows: *"I have 15 years of experience working in Iran in the catheter lab, but here in Germany, I am regarded as an entry-level worker. I am capable of performing many tasks, yet here, external staff is hired to carry them out. I informed them that I was trained to use a specific device, and they replied, 'Well done,' but stated that it was not necessary. The external staff from the company handles those tasks"* (P4).

"In Iran, we had nurse assistants, and many personal care tasks for patients were managed by their families, but here in Denmark, it is different. You must attend to basic patient needs, such as changing diapers, assisting with bedpans, and bathing patients" (P14).

"In Australia, even blood sampling is performed only by specifically designated nurses. My responsibilities have been reduced, and I do not find this satisfying. For instance, if a patient's catheter is dislodged, I am not allowed to fix it. My clinical skills are not being used. Back in Iran, we worked almost at the level of doctors, and we felt truly effective" (P11).

Such accounts reflect the gap between expectations and reality. Many migrated seeking professional advancement but encountered systemic barriers. This mismatch often led to a sense of stagnation, as one participant shared: *"Here in Germany, there is no hierarchy. Everyone operates on the same level. There are no senior positions, which diminishes motivation. I found this disheartening. I migrated with the hope of career advancement, but now I see that those who migrated 10 years ago are engaged in the same work that I, as a newcomer, am doing"* (P2).

Overall, the findings indicate that the professional transition of migrant nurses is a complex process that extends beyond mere adaptation, involving the continuous reconstruction of professional identity within unfamiliar organizational contexts. Factors such as nonrecognition of prior qualifications, limited career advancement opportunities, and language barriers disrupt professional coherence and gradually undermine their professional roles.

Economic vulnerability

The theme of *Economic Vulnerability* reflects the multifaceted financial difficulties experienced by migrant nurses. These difficulties primarily arise from financial strain due to high living costs and economic instability in host countries, significant expenses related to visa procedures, exams, and migration processes, and the negative impact of currency fluctuations on financial stability. Together, these factors create ongoing economic insecurity, often forcing nurses to rely on personal savings or family support to cover essential expenses during and after relocation.

Financial strain was a prominent concern among participants, especially regarding housing and healthcare costs. For instance, a nurse in Australia stated: *"The cost of housing here in Australia is extremely high. We pay around 2,000 Australian dollars (AUD) per month in rent, which is substantial. Even after 11 months here, I still do not have health insurance, and a simple doctor's visit costs me 200 AUD"* (P11).

Similarly, a participant in Denmark highlighted the burden of living expenses and currency disparities: *"The rent here in Denmark is expensive. I pay about 60 million tomans (Approximately 6000 DKK) per month for rent. If we manage to be very frugal, we might save 2,000 to 3,000 DKK, but that is not a large amount"* (P20).

In addition to housing costs, high taxation further constrained financial flexibility: *"Taxes in Denmark are*

very high, and even the locals are dissatisfied with them. You must pay 40%, and sometimes up to 60% of your salary in taxes. If you want to live extremely frugally, you may be able to save a little, but if you wish to maintain a standard lifestyle, saving is virtually impossible" (P16).

Visa and legal processes also imposed significant financial burdens. Many nurses, especially in Australia, had to enter on student visas, incur high educational costs, and face prolonged job insecurity. One participant explained: *"The cost of education in Australia is exorbitant. I sold my house and car in Iran and brought all my savings with me, even borrowing money from my sister. The tuition for just 2 years at university exceeded 3 billion tomans (approximately 80,000 AUD) in Iranian currency. It has been several months since I completed my studies, and despite investing heavily to get registered as a nurse, I still have not found a job. For now, I am forced to work in a nursing home"* (P7).

This quote illustrates the severe financial strain resulting from the high cost of education. The individual, having sold personal assets and borrowed money from family members, now faces challenges in securing suitable employment. This financial burden continues even after the completion of their education.

Another participant noted the need to work unrelated jobs to cover expenses: *"I had to pay 80,000 AUD just for 2 years of study. In addition to the money I brought from Iran, I had to work 9 hours a day in a supermarket to cover both my living expenses and tuition"* (P8).

This statement clearly reflects the intense financial difficulties caused by the combined cost of education and living expenses. Many migrant nurses, in order to meet their financial needs, take up jobs outside their professional fields. This not only exacerbates their financial strain but also potentially has negative implications for their mental and social wellbeing.

Cultural and social dislocation

Cultural and social dislocation emerged as a key challenge faced by migrant nurses in host countries. This included difficulty adapting to the new culture, value conflicts with the host society, experiences of discrimination and racism, social exclusion, and challenges in daily social interactions. One of the main issues involved differences in parenting norms. Many participants voiced concerns over the impact of the host culture on their children's religious and national identities. In the Iranian culture, children are expected to remain dependent on their families until marriage, whereas in many Western societies, early independence is encouraged. One participant explained: *"My daughter, who is only 15 years old, is looking for a job to gain her own income and independence"* (P14).

This quote underscores the stark differences in attitudes toward independence and autonomy. This cultural gap is reflected not only in social behaviors but also in religious and ethical perspectives. Many nurses referred to issues such as the hijab and sexual relationships in host countries, expressing feelings of confusion and disorientation due to the cultural freedoms that are embraced in those societies. For example, one participant commented: *"Schools here are co-educational, and homosexuality is openly accepted. My teenager has quickly adapted to the local culture. I wish I could return to Iran, but I cannot because of my children; they no longer support that idea. I feel trapped"* (P16).

This situation has led to feelings of alienation and concern about the erosion of cultural values and identity among migrant nurses.

Discrimination and racism in the workplace were also identified as significant issues in the study. Many Iranian nurses reported experiencing feelings of exclusion and discrimination in their professional environments. This discrimination often occurred indirectly, through being ignored or through the formation of in-groups among employees of different nationalities. One participant shared her direct experience of feeling ostracized at work as follows: *"In my hospital, I am the only Iranian. Other migrants and Australians have formed groups and support each other, while I feel like I have been left out"* (P11).

Such experiences led to decreased self-esteem and a weakened sense of workplace belonging, negatively affecting professional and personal wellbeing.

In addition, participants described barriers in everyday communication, especially during their initial months in the host country. These challenges made basic administrative tasks, such as opening bank accounts, paying taxes, or finding housing, difficult to manage. Many initially assumed that routine procedures would be simpler and more efficient in the host countries, but encountered unexpected levels of bureaucracy. These issues often resulted in confusion and anxiety. However, participants noted that many of these obstacles gradually eased over time. Some examples of this are as follows: *"One of our challenges was that we did not realize how quickly we needed to complete the tax form. After 2 months, when my husband started working, they told him that because he had not filled out the tax form, he would have to pay 55% in taxes, whereas if he had filled it out on time, he would have paid only 36%"* (P17).

"I had an accident here in Denmark. When the police arrived, I could not explain myself. It was a very uncomfortable experience. It cost me a lot. The police told me that if I did not obtain a driver's license within 6 months, I would not be able to drive for 3 years. I failed the driving test 3 times. On top of the high exam costs, I had to pay a fine of 1,000 kroner each time, which was very expensive" (P17).

"I had difficulty finding a house. I have moved 3 times so far. Even Iranians here in Denmark gave me wrong advice on finding accommodation" (P16).

"Here in Denmark, you must at least be proficient in English. I know of some migrants who, after 4 to 5 months, still could not open a bank account. They were forced to return to Iran" (P18).

Overall, the findings suggest that cultural and social dislocation among migrant nurses involves more than superficial cultural differences. It reflects deeper value conflicts, discrimination, and adaptation challenges in daily and professional life. These barriers can significantly undermine their sense of belonging and social integration in the host country.

Emotional and psychological strain

The theme of emotional and psychological strain captures the complex burdens experienced by migrant nurses. This overarching theme includes three subthemes: Chronic feelings of loneliness and emotional detachment, Homesickness, grief, and anxiety related to separation, and Identity crisis and psychological disorientation. Participants' narratives revealed that migration is not just a geographical shift but an emotionally charged journey that affects psychological stability and the sense of self.

A persistent challenge was the experience of loneliness and longing. Almost all participants spoke of the emotional pain tied to leaving Iran, especially separation from familiar surroundings, close family bonds, and cherished memories. These feelings were intensified among those with elderly parents still in Iran. For many, migration became a moment of reflection and renewed appreciation for their homeland. As one nurse stated: *"You only truly realize what you have lost when you migrate; Our Iran is like paradise"* (P13).

This quote reflects a sense of loss that goes beyond distance. It highlights the emotional and cultural disconnection from one's roots and identity.

Separation from family emerged as a major emotional burden. One nurse explained: *"My biggest problem is being away from my family and feeling like a stranger. When I think that my parents may live for another 20 years and I will only be able to see them once a year, perhaps only 20 more times in total, it is truly painful"* (P3).

This statement highlights not only the depth of homesickness but also the profound sense of vulnerability and isolation that arises from being distant from family. Such feelings can deeply affect an individual's sense of identity as connection with family and the feeling of their support are key pillars of Iranian cultural values.

The grief and longing associated with homesickness were so intense that some participants shared deeply personal and emotional experiences. One nurse, in a moment of despair, expressed: *"Homesickness is unbearable. You might not believe it, but, some nights, I feel so lonely that I search for my father's grave on Google Maps in Behesht Zahra and talk to him"* (P17).

This quote poignantly conveys the deep emotional attachment and connection to one's homeland and family, even in the context of geographical separation. Here, cyberspace becomes a bridge between physical realities and emotional experiences, allowing the migrant to maintain a spiritual connection with cherished places and loved ones.

The sense of loneliness and sadness in the daily lives of migrant nurses was so widespread that another participant emphasized: *"Here in Australia, even when you speak to someone who has been living here for 20 years, there is still sadness. We all carry sorrow, even in moments of peace. I never thought I would miss home so much. We are never truly happy"* (P11).

This illustrates the emotional contradiction migrants live with: outward calm paired with persistent inner sorrow.

The emotional narratives of participants suggest that migration extends beyond social and cultural adjustment, representing a profound emotional disruption in familial and cultural ties. What may appear as mere homesickness often reflects a deeper challenge to one's cultural identity, requiring migrants to reconstruct their sense of self amid significant emotional and cultural displacement.

Discussion

This qualitative study, using a descriptive phenomenological approach, explored the multifaceted challenges faced by Iranian migrant nurses in Germany, Denmark, and Australia. The findings led to the identification of four main themes that illuminated various dimensions of these challenges.

The first theme was professional transition challenges. Participants spoke of numerous obstacles in entering the nursing job market in the host country, including difficulties in securing specialized employment, the complexity of the registration and licensure process, the erosion of professional competencies and limited opportunities for career advancement, and language-related challenges in establishing effective clinical communication. Many participants had initiated their migration based on general awareness of the nursing shortage in the destination countries, without having accurate, comprehensive, or realistic information about the professional conditions, legal requirements, or credentialing procedures. In some cases, the information provided by immigration agencies was not only insufficient but also misleading, resulting in unrealistic expectations and, ultimately, professional disappointment.

These findings are consistent with previous studies that have addressed the professional challenges faced by international nurses, particularly concerning credential recognition, familiarity with professional language, and alignment with the host country's clinical standards.[17] For instance, Indonesian nurses identified the nursing licensure exam in Japan as one of their major challenges,[18] and Filipino

nurses in Norway described the credential evaluation process as highly competitive, prolonged, and exhausting, with some eventually forced to return to their home country due to their inability to secure employment.[19]

Lack of career advancement was another challenge highlighted by several participants who had migrated with the hope of progressing in their careers. Previous studies confirm that the limited opportunities for promotion faced by international nurses is a significant concern and is perceived as a barrier to professional growth.[20,21] For instance, international nurses from China in the United States and Australia reported that their ethnicity acted as a systematic obstacle to their career advancement, restricting their chances of being promoted to managerial positions.[21] Similarly, Indonesian nurses in Taiwan noted the lack of career progression opportunities in Taiwan as a critical professional challenge.[22] This negative experience was more frequently reported by nurses who had previously held higher positions in their home countries, underscoring the disillusionment faced by those seeking to elevate their professional status abroad.[20,23]

In addition to the aforementioned issues, another prominent phenomenon among the professional challenges faced by migrant nurses is skill degradation. Nursing in Iran is a fully academic and university-level profession, and participants in this study indicated that they expected to hold a role equivalent to their professional nursing position in Iran within the host country, working in a healthcare system equipped with advanced technology. However, the reality they encountered fell short of these expectations.

Previous studies also confirm that migrant nurses experience challenges related to skill degradation during their transition. Many nurses, due to their qualifications not being recognized, are forced to work in different and often less respected positions in the host country, which offer lower salaries and status compared to other healthcare roles.[24] For instance, Nepali nurses working in the UK reported that, through employment in care homes or even as registered nurses, they gradually became deskilled. After several years, they lacked the confidence to return to acute care, resulting in frustration, low job satisfaction, and decreased morale.[25]

Similarly, registered African nurses reported feelings of skill degradation, having to perform simple care tasks instead of engaging in more challenging roles in their host countries.[26] Filipino nurses in Norway also noted that their insufficient proficiency in Norwegian hindered them from securing nursing positions. At the outset of their new lives in Norway, they sought alternative income sources, such as working in bakeries or kindergartens, or collecting bottles for recycling. Many of them worked long hours in care homes to improve their Norwegian language skills and enhance their credentials, which led to feelings of exploitation and undervaluation.[27] Likewise, Indonesian nurses expressed dissatisfaction with not being permitted to perform injections or suction in Taiwan as these tasks were part of their responsibilities back home.[22]

A significant reason for skill degradation is the difference in nursing roles between Iran and the host countries. Many healthcare systems in developed countries adopt a more independent, patient-centered, or holistic approach to nursing care, whereas developing countries tend to follow a more task-focused and medically-centered model of nursing.[28] This difference can be attributed to the fact that, in developing countries, families have a moral and practical commitment to providing personal care in the daily lives of patients, leading nurses to refrain from performing routine tasks such as bathing or feeding, which are regarded as family responsibilities.[29]

In contrast, in some developed countries, patients are entirely dependent on nurses for their personal care.[27[For example, a study showed that Indonesian nurses in Japan reported that, unlike in Indonesia, assisting with personal care tasks such as bathing, changing diapers, and toileting is the responsibility of the nurse in Japan.[30] Numerous other studies have confirmed that migrant nurses from certain East Asian countries are reluctant to perform personal care tasks for patients in Australia or to feed patients as families in their home countries typically handle these duties. These nurses view performing such tasks as degrading to their professional status as registered nurses.[31]

Levels of professional autonomy in healthcare systems vary widely across countries, with some cultures placing greater emphasis on hierarchical management styles where individuals are expected to comply with directives without question. For example, in developing countries like Iran, nurses are not expected to question the absolute authority of physicians, whereas in developed countries, nurses have greater independence and authority in decision-making in collaboration with broader care teams.[32]

Communication barriers, particularly limited proficiency in the host country's primary language, were also identified as a major challenge in establishing effective clinical communication. This issue was more frequently reported by migrants to Germany and Denmark. Among those moving to these countries, individuals who were proficient in English faced fewer obstacles as local populations often have a good command of English, allowing for support when migrants struggled to express themselves in the local language.

However, even among migrants to Australia, an English-speaking country, language barriers, stemming from insufficient English proficiency and the Australian accent, were cited as challenges. Numerous prior studies have highlighted language as one of the most daunting issues faced by international nurses. Language serves as a fundamental tool for strengthening relationships and establishing social identity among individuals, with

communication being particularly critical in nursing care.[30] Differences in semantics due to language and accent can significantly affect nurses' ability to communicate effectively in both English-speaking and non-English-speaking countries. Even for those fluent in English, variations in accent, as well as the multiple meanings and informal uses of words, can present substantial obstacles to successful communication.[33]

An Australian study indicated that challenges in meeting formal language requirements represent considerable barriers for groups of nurses from South Asia and India seeking registration.[34] Similarly, internationally educated nurses in Australia, particularly those from non-English speaking backgrounds, reported varying levels of frustration and anxiety regarding effective communication with colleagues and patients.[35] International nurses working in Iceland, the United States, and the UK found answering phones at work challenging due to differences in pronunciation, accent, terminology, and the fear of miscommunication.[36,37] Likewise, Indonesian nurses in Japan and African migrant nurses identified language barriers as their most significant challenge.[26,30]

Failures in communication resulting from language barriers can have a detrimental effect on patient safety and the overall quality of care.[38] For instance, one study revealed that miscommunication and misunderstandings between German nurses and migrant nurses led to a perceived decrease in the quality of patient care and an increased workload for host country nurses. Language proficiency appears to be a crucial factor influencing stress levels and occupational adaptation among international nurses, playing an essential role in their sense of belonging and overall positive experiences in the workplace.[37]

The second theme focused on Economic Vulnerability, which participants identified as a significant issue. The substantial costs associated with preparing documents for visa applications, taking language and nursing qualification exams, and, in some cases, the high fees charged by immigration agencies prior to migration, along with the high costs of living and studying in host countries, largely attributable to the disparity in currency value between Iran and these nations, resulted in a considerable financial burden for nearly all participants.

The financial challenges identified in this study are consistent with findings from previous research. For instance, several studies have shown that the decision to migrate to Australia has imposed considerable financial and social stress on nurses and their families, complicating their situation before departure.[39,40] Furthermore, financial stress has also been reported by nurses who felt discriminated against and manipulated by fraudulent recruitment agencies.[34]

In the third theme, cultural and social challenges were identified as key barriers to the adaptation of migrant nurses. Participants reported cultural conflicts arising from differences in beliefs, values, and customs, particularly during the initial months of their stay in the host country. Concerns about assimilation into the dominant culture and the erosion of their cultural and religious identity, especially among migrants with children, were frequently mentioned.

Previous research also indicates that migrant nurses often experience cultural dissonance when faced with differing social and professional values, which can lead to a sense of incongruity and frustration.[41,42] Differences in language, customs, and ideologies compared to the dominant culture frequently result in feelings of alienation and a lack of belonging.[43] This sense of estrangement is often exacerbated by unfamiliarity with the local culture and a lack of cultural understanding from local colleagues.[43]

Overall, the sudden exposure to ethnic diversity in multicultural countries such as Australia can be a source of considerable stress for internationally educated nurses, particularly those from predominantly homogeneous societies.[23]

Racism and discrimination also emerged as significant cultural challenges reported by participants. Some Iranian nurses believed that employers did not treat them equitably compared to local staff and often engaged in discriminatory practices. This perception extended to comparisons with migrant nurses from other countries, with some participants feeling that host-country employers provided greater support to nurses from other nationalities.

Additionally, several participants noted a reluctance among foreign nurses, from both the host country and other migrant groups, to establish social or professional connections with Iranian nurses, contributing to feelings of isolation and loneliness. Instances of open hostility and racism in both workplace settings and the broader community have been documented in previous studies on international nurses.[44,45]

Prior research has indicated that racism manifests in various forms, including patients' attitudes toward migrant nurses or host country nurses' perceptions of migrant nurses.[21,44] African migrant nurses reported that their skin color fundamentally shapes the way they are treated, with their opinions often dismissed due to being Black.[46] Similarly, polish (white) and Filipino (nonwhite) migrant nurses in Norway experienced differing treatment, with Filipino nurses of color encountering instances of racism.[47]

Additional studies have reported uncomfortable situations where colleagues of migrant nurses intentionally misunderstand, undermine their professional skills, refuse to assist, and sometimes harass international nurses.[17,48] In research conducted in Germany, Australia, and the UK, migrant nurses reported feeling vulnerable in their new workplaces due to mechanisms of alienation and rejection.[49-51]

The fourth theme centers on the psychological and emotional challenges reported by Iranian migrant nurses, with a shared sense of homesickness and emotional detachment from family and close friends being among the most prevalent experiences. According to the findings of this study, longing for familial and emotional connections not only intensifies negative feelings such as sadness and grief but also significantly hinders the process of cultural and social integration.

These findings align with prior research indicating that international nurses often experience a deep sense of nostalgia after migration, one that involves a heightened reverence for memories, especially those involving loved ones left behind in the home country.[52,53] This emotional state can become a latent yet powerful barrier to effective integration in the host society.[23]

International migration offers Iranian nurses opportunities for personal and professional development; however, it also exposes them to considerable psychological, social, and structural challenges.[20] These challenges largely stem from the discrepancies between the migrants' expectations and the actual conditions encountered in the destination countries.[54,55] Despite the severe nursing shortage within Iran, migration continues for a range of personal and professional reasons.

From a human rights perspective, restricting the right to migrate is neither feasible nor ethically justifiable. Nevertheless, adopting effective and ethically sound migration governance policies can substantially alleviate these challenges.

The absence of transparent recruitment mechanisms in destination countries, compounded by insufficient oversight from regulatory bodies such as the Ministry of Health, has resulted in a failure to adequately safeguard the interests of both migrant nurses and the Iranian healthcare system. In some countries, this lack of institutional support manifests in feelings of abandonment, psychological distress, and professional disillusionment, factors that significantly obstruct both social and occupational integration. Furthermore, the inadequate regulation of migration agencies has opened the door to exploitative practices, with many nurses encountering conditions vastly different from what was initially promised.[56]

Despite the growing demand for Iranian nurses in destination countries, the lack of attention to cultural, emotional, and social integration processes prevents full utilization of their expertise in addressing nursing workforce shortages. Designing culturally sensitive integration pathways tailored to the specific needs of Iranian nurses, including attention to religious and social dimensions, could facilitate smoother transitions.

While countries such as Australia have developed more established frameworks for welcoming international nurses, others like Germany and, particularly, Denmark are still in the early stages of developing effective integration strategies, with limited empirical research on the experiences of migrant nurses in these contexts.[57] Recent attempts to reduce legal barriers to migration in these countries reflect a lack of institutional experience in accommodating and integrating foreign-trained nurses when compared to long-standing immigration countries like Australia.[57]

Ultimately, the development of bilateral agreements between countries of origin and destination represents a strategic mechanism for mitigating the challenges faced by migrant nurses while ensuring mutual benefits. Such agreements should be founded upon principles of transparency, fairness, and protection of migrant workers' rights, while also upholding the quality of patient care.[58] Moreover, implementing retention strategies in the Iranian health system and establishing supportive reintegration pathways for returning migrants could play a crucial role in reducing the adverse outcomes associated with migration.

Recent data indicate a shift in the migration trend of Iranian nurses. While this trend had previously been on the rise, the Deputy for Nursing of the Ministry of Health announced its halt in 2024, and statistics from the Nursing Organization show a 35% decline in migration certificate applications from approximately 2000 in 2023 to fewer than 1300 in 2024.[59] Nevertheless, the structural and persistent challenges faced by migrant nurses remain significant. According to the Deputy for Nursing of the Ministry of Health, many of these individuals have been unable to obtain official licensure and have been compelled to work in positions below their professional qualifications.[59] Thus, despite the relative decline in migration rates, the issues identified in this study persist and demand continued attention and support from policymakers both in Iran and in destination countries.

This phenomenological study, involving 20 Iranian migrant nurses (8 in Australia, 8 in Denmark, and 4 in Germany), explored the professional challenges they face in host countries. While the small sample size limits the generalizability of findings, the significance of the study lies in its status as the first research of its kind conducted in Iran. A key limitation was the relatively short average duration of participants' residence in the host countries, approximately 2.5 years, which may not fully capture the evolving nature of their experiences over time. Additionally, interviews were conducted via digital platforms such as Skype, WhatsApp, Telegram, and Google Meet. Although these tools facilitated access to participants, frequent Internet disruptions occasionally interrupted the interviews, potentially affecting the depth and richness of the qualitative data collected.

Conclusion

This study identified the multifaceted challenges faced by Iranian migrant nurses in Germany, Denmark, and Australia across professional, economic, social, cultural, and psychological domains. Among these, limited language proficiency, particularly in professional and social interactions, emerged as a major barrier to integration and career success. Given the central role of language competence in clinical performance and intercultural communication and the presence of longstanding deficiencies in English language education in Iran, such as delayed instruction and traditional teaching methods, structural reform is required in national education policies to better prepare healthcare professionals for international labor markets. Targeted educational programs focusing on language, intercultural, and soft skills can facilitate the professional transition of migrant nurses by familiarizing them with the structure, expectations, and culture of healthcare systems in host countries. Developing these competencies is also critical for enhancing resilience and effectiveness in multicultural work environments. Host institutions must provide structural support, including legal, financial, and psychological counseling, to alleviate migration-related stressors and strengthen nurses' professional and social adjustment. The findings highlight the need for ethical migration policies aligned with the World Health Organization's Global Code of Practice on the International Recruitment of Health Personnel to protect migrant nurses' rights while preventing human resource depletion in source countries. Achieving these goals requires multisectoral collaboration among governments, policy-makers, international organizations, academic institutions, and healthcare employers in host countries. A responsible and equitable approach to educational investment, fair migration frameworks, and sustained institutional support is essential for ensuring mutual benefits for both migrant health workers and global healthcare systems.

Acknowledgements

The authors wish to express their sincere gratitude to all the nurses who participated in this study for their invaluable cooperation.

Financial support and sponsorship

Tehran University of Medical Sciences

Conflicts of interest

Nothing to declare.

References

1. Buchan J, Calman L. The Global Shortage of Registered Nurses: An Overview of Issues and Actions. Geneva: International Council of Nurses; 2004.
2. Gostin LO. The international migration and recruitment of nurses: Human rights and global justice. JAMA 2008;299:1827-9.
3. Simoens S, Villeneuve M, Hurst J. Tackling Nurse Shortages in OECD Countries. Paris: Organisation for Economic Co-operation and Development; 2005.
4. World Health Organization. Global Strategy on Human Resources for Health: Workforce 2030. Geneva: World Health Organization; 2016.
5. Efendi F, Mackey TK, Huang MC, Chen CM. IJEPA: Gray area for health policy and international nurse migration. Nurs Ethics 2017;24:313-28.
6. Didbaniran News Agency. The immigration statistics of Iranian nurses have doubled. Available from: https://www.didbaniran.ir/fa/tiny/news-198909. [Last accessed on 2025 Mar 18].
7. Kamali M, Niromand Zandi K, Ilkhani M, Shakeri N, Rohani C. The relationship between job satisfaction and desire to emigrate among the nurses of public hospitals in Tehran. J Health Admin 2020;23:11-6.
8. Heidari A, Shah Bahrami M, Koochak F, Khatirnamani Z. Desire for emigration and its relationship with social capital among nurses working in teaching hospitals in Golestan, Iran. Payesh (Health Monitor) 2023;22:301-12.
9. Iranian Nursing Organization. Nurse shortage: An ongoing challenge in healthcare systems. Available from: http://ino.ir/1/1578/1316. [Last accessed on 2025 Mar 10].
10. Kordes J, Pütz R, Rand S. Analyzing migration management: On the recruitment of nurses to Germany. Soc Sci 2020;9:19.
11. Zander-Jentsch B, Busse R. Relief for nursing staff? Minimum staffing requirements in hospitals. CNE Pflege Management. 2018;5:6-9.
12. Prognos AG. Nursing care landscape 2030: A study by Prognos AG commissioned by the vbw – Bavarian Business Association. Munich: Prognos AG; 2012.
13. The Local Denmark. Almost one in eight nurses leave Danish health service. June 20, 2023. Available from: https://www.thelocal.dk/20230620/almost-one-in-eight-nurses-leave-danish-health-service. [Last accessed on 2025 Feb 18].
14. Health Workforce Australia. Australia's future health workforce: Nurses – detailed report. Canberra: Department of Health; 2014. Available from: https://www.health.gov.au/sites/default/files/documents/2021/03/nurses-australia-s-uture-health-workforce-reports-detailed-report.pdf. [Last accessed on 2025 Feb 10].
15. Shorey S, Ng ED. Examining characteristics of descriptive phenomenological nursing studies: A scoping review. J Adv Nurs 2022;78:1968-79.
16. Praveena KR, Sasikumar S. Application of Colaizzi's method of data analysis in phenomenological research. Medico-Legal Update 2022;21:2800.
17. Pressley C, Newton D, Garside J, Simkhada P, Simkhada B. Global migration and factors that support acculturation and retention of international nurses: A systematic review. Int J Nurs Stud Adv 2022;4:100083.
18. Kurniati A, Chen CM, Efendi F, Ogawa R. A deskilling and challenging journey: The lived experience of Indonesian nurse returnees. Int Nurs Rev 2017;64:494-501.
19. Nortvedt L, Lohne V, Dahl K. A courageous journey: Experiences of migrant Philippine nurses in Norway. J Clin Nurs 2020;29:468-79.
20. Alexis O, Vydelingum V. The experiences of overseas black and minority ethnic registered nurses in an English hospital: A phenomenological study. J Res Nurs 2005;10:459-72.
21. Zhou Y, Windsor C, Theobald K, Coyer F. The concept of

difference and the experience of China-educated nurses working in Australia: A symbolic interactionist exploration. Int J Nurs Stud 2011;48:1420-8.
22. Nursalam N, Chen CM, Efendi F, Has EMMA, Hidayati L, Hadisuyatmana S. The lived experiences of Indonesian nurses who worked as care workers in Taiwan. J Nurs Res 2020;28:e78.
23. Pung LX, Goh YS. Challenges faced by international nurses when migrating: An integrative literature review. Int Nurs Rev 2017;64:146-65.
24. Moyce S, Lash R, de Leon Siantz ML. Migration experiences of foreign educated nurses: A systematic review of the literature. J Transcult Nurs 2016;27:181-8.
25. Adhikari R, Melia KM. The (mis) management of migrant nurses in the UK: A sociological study. J Nurs Manag 2015;23:359-67.
26. Bayuo J, Abboah-Offei M, Duodu PA, Salifu Y. A meta-synthesis of the transitioning experiences and career progression of migrant African nurses. BMC Nurs 2023;22:104.
27. Burner OY, Cunningham P, Hattar HS. Managing a multicultural nurse staff in a multicultural environment. J Nurs Adm 1990;20:30-4.
28. Al-Hamdan ZM, Al-Nawafleh AH, Bawadi HA, James V, Matiti M, Hagerty BM. Experiencing transformation: The case of Jordanian nurses immigrating to the UK. J Clin Nurs 2015;24:2305-13.
29. Brunton M, Cook C. Dis/Integrating cultural difference in practice and communication: A qualitative study of host and migrant registered nurse perspectives from New Zealand. Int J Nurs Stud 2018;83:18-24.
30. Efendi F, Chen CM, Nursalam N, Indarwati R, Ulfiana E. Lived experience of Indonesian nurses in Japan: A phenomenological study. Japan J Nurs Sci 2016;13:284-93.
31. Smith CD, Fisher C, Mercer A. Rediscovering nursing: A study of overseas nurses working in Western Australia. Nurs Health Sci 2011;13:284-91.
32. Neiterman E, Bourgeault IL. Cultural competence of internationally educated nurses: Assessing problems and finding solutions. Can J Nurs Res 2013;45:88-107.
33. Xu Y, Gutierrez A, Kim SH. Adaptation and transformation through (un) learning: Lived experiences of immigrant Chinese nurses in US healthcare environment. Adv Nurs Sci 2008;31:E33-47
34. Zhong Y, McKenna L, Copnell B, Zhao W, Moss C. Professional adaptation experiences of Chinese migrant nurses in Australia: A qualitative study. West J Nurs Res 2023;45:626-33.
35. Philip S, Woodward-Kron R, Manias E. Overseas qualified nurses' communication with other nurses and health professionals: An observational study. J Clin Nurs 2019;28:3505-21.
36. McGrath P, Henderson D, Holewa H. Language issues: An important professional practice dimension for Australian international medical graduates. Commun Med 2013;10:191-200.
37. Limpangog CP. Resuming the "skilled worker" identity: The Filipinas' strategies in labor market participation in Melbourne, Australia. Kritika Kultura 2016;26:523-607.
38. Stankiewicz G, O'Connor M. Overseas qualified nurses in Australia: Reflecting on the issue. Aust J Adv Nurs 2014;31:32-8.
39. Woodbridge M, Bland M. Supporting Indian nurses migrating to New Zealand: A literature review. Int Nurs Rev 2010;57:40-8.
40. Walters H. The experiences, challenges and rewards of nurses from South Asia in the process of entering the Australian nursing system. Aust J Adv Nurs 2008;25:95-105.
41. Higginbottom GM. The transitioning experiences of internationally-educated nurses into a Canadian health care system: A focused ethnography. BMC Nurs 2011;10:14.
42. O'Brien T, Ackroyd S. Understanding the recruitment and retention of overseas nurses: Realist case study research in National Health Service hospitals in the UK. Nurs Inq 2012;19:39-50.
43. Likupe G, Archibong U. Black African nurses' experiences of equality, racism, and discrimination in the National Health Service. J Psychol Issues Organ Cult 2013;3:227-46.
44. Crawford T, Roger P, Candlin S. Are we on the same wavelength? International nurses and the process of confronting and adjusting to clinical communication in Australia. Commun Med 2016;13:263-75.
45. Tie YC, Birks M, Francis K. Playing the game: A grounded theory of the integration of international nurses. Collegian 2019;26:470-6.
46. Brunton M, Cook C, Kuzemski D, Brownie S, Thirlwall A. Internationally qualified nurse communication-A qualitative cross-country study. J Clin Nurs 2019;28:3669-79.
47. Connor JB, Miller AM. Occupational stress and adaptation of immigrant nurses from the Philippines. J Res Nurs 2014;19:504-15.
48. Montayre J, Holroyd E. The global Filipino nurse: An integrative review of Filipino nurses' work experiences. J Nurs Manag 2018;26:338-47.
49. Zanjani ME, Ziaian T, Ullrich S. Challenges and experiences of overseas qualified nurses adjusting to new roles and health care systems: A narrative review of the literature. Singapore Nurs J 2018;45:7-16.
50. Newton S, Pillay J, Higginbottom G. The migration and transitioning experiences of internationally educated nurses: A global perspective. J Nurs Manag 2012;20:534-50.
51. Javanmard M, Steen M, Vernon R, Newnham E. Experiences of internationally qualified midwives and nurses in Australia and other developed nations: A structured literature review. Evidence Based Midwifery 2017;15:95-100.
52. Ryan JG. Adjusting to the United States Healthcare Workplace: Perceptions of Internationally Born and Educated Registered Nurses [doctoral dissertation]. Chester, PA: Widener University; 2010.
53. Jose MM. A Phenomenological Study of the Lived Experiences of Foreign Educated Nurses Working in the United States of America [doctoral dissertation]. Galveston, TX: University of Texas Medical Branch; 2008. Available from: https://utmb-ir.tdl.org/items/62a78a89-1c2b-46f5-9a74-8584f43a4add.
54. Chicca J, Bindon S. New-to-setting nurse transitions: A concept analysis. J Nurses Prof Dev 2019;35:66-75.
55. Ke YT, Stocker JF. On the difficulty of finding one's place: A qualitative study of new nurses' processes of growth in the workplace. J Clin Nurs 2019;28:4321-31.
56. Stuart P. Overseas nurses' experience as support workers in the UK. Nurs Res Care 2012;14:660-3.
57. Smith JB, Herinek D, Woodward-Kron R, Ewers M. Nurse migration in Australia, Germany, and the UK: A rapid evidence assessment of empirical research involving migrant nurses. Policy Polit Nurs Pract 2022;23:175-94.
58. Stokes F, Iskander R. Human rights and bioethical considerations of global nurse migration. J Bioethical Inquiry 2021;18:429-39.
59. Mehr News Agency. Economic challenges of 2,000 Iranian nurses in Denmark. Available from: https://www.mehrnews.com/x387kx. [Last accessed on 2025 June 23].