

How Do Public Health Nurses Work and Support Mothering Refugee Women in the
Community?

by

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B.N., University of Calgary, 1998

M.N., University of Victoria, 2014

A Dissertation Submitted in Partial Fulfillment of the
Requirements for the Degree of

DOCTOR OF PHILOSOPHY

in the School of Nursing

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University of Victoria

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We acknowledge with respect the Lekwungen peoples on whose traditional territory the
university stands and the Songhees, Esquimalt and WSÁNEĆ peoples whose historical
relationships with the land continue to this day.

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Abstract

My doctoral studies contribute toward situating the health of mothering women who have been forcibly displaced within the nursing discipline. Specifically, public health nursing processes used while working with and supporting mothering women who have been forcibly displaced were explored. I use the terms *mothering women who have been forcibly displaced* to convey and articulate the locations shaping this specific population of women. In doing so, I put emphasis on the women who have been impacted by forcible displacement and pushed into a marginalized state. This approach to terminology also conveys the multiple complexities experienced by these women which public health nurses have the opportunity to engage with.

The following question guided this dissertation: *How do public health nurses work with women who are mothering and managing the effects of their refugee status?* This question was approached using two distinct methodologies. The first was a Joanna Briggs Institute (JBI) qualitative systematic review in which I identified, critically appraised and synthesized current knowledge on nurses' experiences of providing care to mothering women who have been forcibly displaced. Of note, the JBI review question was broadened to include nurses caring for women experiencing any form of precarious migrant status. This was due to the limited number of articles addressing the concept of nurses caring specifically for maternal refugee women. The second approach was a constructivist grounded theory (CGT) using intersectionality as an analytical tool. In this study I described the processes public health nurses used to establish trusting relationships with mothering refugee women.

Findings within the JBI review and CGT study included nurses identifying inequities women faced as stemming from their precarious migrant status and thereby needing to flex care

provision to meet women's needs. The findings also demonstrated the need to examine uptake of trauma-informed principles within care with focus on how organizations are structurally supporting nursing in their practice. I conclude this dissertation with the Afterword Chapter which is a summary and synthesis of significant findings and nursing implications.

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Acknowledgements

This dissertation would not have been possible without the passion and commitment of the public health nurses who participated. I am grateful for these nurses who carved space in their busy days to describe their work and dedication to the forcibly displaced women they served. Mentor, guide, advisor, supporter and forward-thinker – these are only some of the words that come to mind when I describe my supervisor, Dr. Lenora Marcellus. Her pragmatic philosophy, love for the nursing discipline and passion for coaching infused my path through doctoral studies with opportunities to grow as a writer, thinker and synthesizer of knowledge. She built my capacities to peel back layers and discover my potentials. I am forever thankful for Lenora’s kindness, openness, and grateful for the hours we spent together philosophizing, mapping and exploring.

To my committee members, Dr. Joyce O’Mahony and Dr. Nancy Clark, thank you both for the time you spent on my work and for your unique perspectives that helped shape this dissertation. Your dedication to the population of forcibly displaced women has inspired me to continue on with crafting my own program of research and continue working together toward shedding light on the issues these women face.

I would like to acknowledge Dr. Carol Gordon, University of Victoria librarian, whose expertise helped shape my Joanna Briggs Institute (JBI) systematic review and who guided me through navigation of the literature. I also acknowledge Dr. Diane Butcher who provided mentorship related to the JBI qualitative systematic review process and to being a focused doctoral student.

I give thanks to the Grounded Theory Club members, for the scholarly discussions where I learned so much about engaging with my research process, and for having interest in my work

and providing feedback that has shaped and inspired my hopes for being a budding grounded theorist!

I also acknowledge the University of Victoria, School of Nursing, for providing support and fellowship funding in the first years of my program.

Lastly, I give my sincere gratitude to the professors who shaped my thinking within the initial coursework years of my doctoral program: Dr. Gweneth Doane, Dr. Anne Bruce, Dr. Marjorie MacDonald, Dr. Anastasia Mallidou, Dr. Maya Gislason, and Dr. Marjorie MacIntyre.

Dedication

Entering into a doctoral program was a profound calling that could not be ignored. Through my circle of support I leaped into a chapter in my life that I am very blessed and grateful for. This circle includes my family and faith. I dedicate this dissertation to these two pillars that have unwaveringly supported my passion for nursing and for following my curiosities and worries about wicked problems affecting populations marginalized by uncontrollable forces.

To my husband, Areez Kassam, who has stood next to me throughout my career and encouraged continuous pursuit of education, who believes in my dreams to contribute to nursing science and who makes me smile everyday through his laughter, his insightful logic and his '*hakuna matata*' philosophy.

To my children, Emaan and Rayyah, who have watched me commit to graduate studies through most of their foundational years, who have cheered me on, and who have inspired me with their love for learning, their desire to help those affected unjustly, and their affinity for fairness and equity.

To my mother and father, for immigrating to Canada, for working hard to carve out futures for my brother and myself, and for grounding me in faith and the importance of life-long learning.

“...The danger is that knowledge gaps so often run the risk of becoming empathy gaps. The struggle to remain empathetically open to the Other in a diversifying world is a continuing struggle of central importance.”

- His Highness the Aga Khan, Stephen Ogden Lecture at Brown University, 2014 -

Chapter One: The Foreword

My overarching aims of this dissertation included situating nursing within scholarship addressing the health of mothering women who have been forcibly displaced. Additionally, I aimed to shed light on the role of public health nurses who work with mothering refugee women in the community. To demonstrate my contributions, I constructed a publication-based dissertation composed of four scholarly pieces: a Joanna Briggs Institute (JBI) systematic review of qualitative evidence protocol and report, a methodology manuscript, and a manuscript focused on a constructivist grounded theory (CGT) inquiry into my substantive area of research. This publication-based dissertation embodies my contributions to nursing science within the area of public health nursing and the processes used in working with mothering women who have been forcibly displaced. This foreword is reflective of how my dissertation package was shaped philosophically by my critical feminist orientation as well as by current knowledge, doctoral course experiences, and emergent critical social theory. Specifically, I focus on how intersectionality was conceptualized and applied throughout the construction and employment of this dissertation.

Coming from a public health nursing background, my career has been practice-oriented centering on working with marginalized populations. Most of my practice has focused on mothering women and their families. Populations that have sparked concern within my care provision experiences have included women with precarious migrant statuses. Migrant status was one health determinant that I saw going unrecognized across healthcare delivery contexts, including within guiding texts and policy documents developed to support public health nursing practice. This reflected my feelings of being ill-equipped as a public health nurse (PHN) to understand and address the health needs of this group of women. To

understand more about my learning needs and the paucity of guidance, I pursued a Masters in Nursing and completed a project on understanding current knowledge around immigrant and refugee maternal mental health (Kassam, 2019). Findings included how women with precarious migrant statuses experienced more health disparities than women with non-forcibly displaced status. Examples of disproportionate health experiences within this review involved inequitable access to health services, higher rates of caesarean sections, and higher prevalence of varying mental health concerns including postpartum depression and post-traumatic stress disorder (Alvi et al., 2012; Anderson et al., 2017; Kandasamy et al., 2013; O'Mahony et al., 2012; O'Mahony et al., 2013; Stewart, et al., 2008; Sword et al., 2006; Vigod et al., 2017; Zelkowitz et al., 2004; Zelkowitz et al., 2008). Although some literature addressed this group of women's unique and disparate health concerns, they were often clustered together with those who voluntarily migrated. This clustering seemed to conflate the experiences of an under researched population. An additional gap within the literature was how conceptualizations of health determinants had minimal focus on forced migration as well as the impacts of gender and culture on the forced migration experience. Lastly, there was minimal scholarship related to public health nursing perspectives on caring for mothering women experiencing health impacts of forced migration. This integrative literature review (Kassam, 2019) formed the foundation of a profound calling for me to further explore the health of mothering women who have been forcibly displaced from a public health nursing lens.

Purpose and Research Questions

The purpose of this dissertation was to contribute to under researched areas of public health nursing and their work with populations experiencing multiple complexities. The population focused on for this dissertation was mothering women who have been forcibly

displaced. Guiding this dissertation was the initial overarching question: *How do public health nurses work and support mothering refugee women in the community?* I employed two distinct methodologies to answer this question: a systematic review of qualitative evidence guided by the JBI methodology and a CGT using intersectionality as an analytical tool. As a result, two research questions were developed.

The first research question that guided my JBI systematic review of qualitative evidence was: *What are the experiences of nurses caring for maternal immigrant and refugee women?* A review protocol was developed and published (see Chapter 2) and the systematic review report that has been submitted for publication and currently under editorial review (see Chapter 3). The purpose of this systematic review was to identify, critically appraise and synthesize qualitative studies that focused on nurses' care provision among mothering women who have been forcibly displaced. The findings provide accessible evidence for policy makers, educators and practitioners to draw from and guide processes and protocols aimed at delivering care to immigrants and refugees.

The second research question I entered into my CGT study with was: *How do public health nurses work and support mothering refugee women in the community?* Although this is the same question I previously mentioned that guided this dissertation, it is important to note that this question shifted during the research process to embody the basic social problem voiced by participants. During the data collection and analysis process, the basic social problem conveyed by participants was: How do PHNs establish trusting relationships with mothering refugee women while managing broader structural forces? This study has been prepared for publication (see Chapter 5) using the proposed study design that has been published (see Chapter 4). The purpose of the CGT study was to explicitly apply intersectionality with CGT to construct a mid-range theory describing processes PHNs use in

their work with mothering refugee women. In doing so, the PHN role, which often goes unnoticed, is made more visible within the context of the current state of health service provision and health issues faced by mothering refugee women from the PHN perspective.

Background

Public health nursing is a discipline rooted in the population health approach that targets improvement of health while also disruption of health inequities among population groups. Population health has been widely regarded as a framework that shifts the focus of healthcare provision away from the individual toward recognizing broader issues shaping health (Batchelor, 2012; Butterfield, 2017; Radzynski, 2007.) However, the population health framework is not new. First attempts at understanding influences on health have been documented as hygiene-focused initiatives, but quickly shifted to the injustices of power and social position. Looking back to the early 20th century, health and healthcare were shaped by positivist, biomedical care models riddled with colonial effects of privileging those with social status and economic power (Irwin & Scali, 2007). The need to address widening health disparities was minimal, the aftermath of World War II stimulated a global movement toward enhancing public health (Irwin & Scali, 2007; Radzynski, 2007). By 1948, the need for a shared vision of moving toward tackling social conditions influencing health was agreed upon and the World Health Organization (WHO) was formed to navigate understandings of health (WHO, 2018a).

While much of Canadian history involved public health achieving milestones that promoted health and prevented disease, most efforts highlighted involved efforts around how care was delivered. For example, efforts to manage high infant mortality rates among the First Nations population in the 1950s focused on deployment of ‘non-Aboriginal midwives’ and having women deliver their babies in hospitals or nursing stations (Canadian Public

Health Association [CPHA], 2010). This biomedical, quarantining approach to managing health gradually refocused to notions of population health in the 1974 Lalonde Report which concentrated on lifestyle change and personal behavior change to influence health risks (Government of Canada, 2012). However, the report's main focus was biomedical research and understanding how human behaviour reflected 'self-imposed risks' (MacDougall, 2007) which fostered a blaming-approach to complex populations. Moreover, MacDougall (2007) highlights how the 1974 Lalonde Report lacked specific ways to implement health promotion activities which left provincial governments attempting to implement health education while perpetuating antiquated strategies. Over ten years later, WHO held its first International Conference on Health Promotion in Ottawa, making Canada among the first countries to reorient the notion of population health (WHO, 2018b). Development of the 1986 Ottawa Charter for Health Promotion provided a platform for the Canadian health sector to build a framework on developing broad actions that foster health-for-all. Ultimately, the concepts in the 1986 Ottawa Charter for Health Promotion of broad action creating impact at the individual level were slowly taken up in academic and government domains (MacDonald et al., 2013). However, this mindset of population health was not new to nursing.

Achieving equitable health guided by a population health approach is a process steeped in nursing (MacDonald et al., 2013). For example, Falk-Rafael and Betker (2012) highlighted PHNs partnering with community groups to increase their capacity to communicate with municipal government decision-makers around the need for no-smoking by-laws. This example demonstrates significance of the PHN role in engaging with political forces through empowering community voices. Shifting focus to how individual determinants can inform broad forces is a move that resonates within the nursing discipline. For instance, the Western historical conceptualization of nursing looks at Florence

Nightingale's focus on multiple dimensions of health influencers including social, economic and environmental (Kagan, 2014). With Nightingale working within these broad health influences, it is significant to highlight her ethical intentions of achieving health for all patients. Lillian Wald, a contributor to developing public health nursing, extended this intention in 1915 by influencing nurses to hone in on how health is shaped by distal, environmental factors (MacDonald et al., 2013). These birds-eye views on health fit with holistic and social justice assumptions of nursing where distal structures and ideologies that perpetuate inequity are revealed. Social justice is an overarching principle within public health nursing, which is likely why PHNs have the capacity to naturally take up population health approaches.

Population health discourse has evolved over time. Terms that allude to population health, such as *upstream thinking*, have been used within healthcare discourse and are not new to nursing (Butterfield, 2017; MacDonald et al., 2013). In fact, examples of such thinking can be traced back to the early 20th century where nurses were deployed into communities to address appalling living conditions among populations living in poverty (Edwards, 2009). In working with such communities, these PHNs were exposed to the harsh realities of how class differential influenced health experiences. As a result, public health nursing competencies have evolved to ensure PHNs are attentive to disruption of inequities embedded in broader forces (CHNC, 2009; Canadian Nurses Association [CNA], 2013). Significant to the PHN role are principles that intersect and inform practice. Included in these principles are social justice, equity, ethics, and human rights (CHNC, 2009; CNA, 2006; Easley & Allen; 2007).

The United Nations High Commissioner for Human Rights provides a definition of social justice which nursing associations, such as CNA, lean on. This definition states that all

humans must have “the right to live in dignity and freedom and to enjoy the fruits of social progress and should, on their part, contribute to it,” (CNA, 2010). As Boutain (2005) highlights, nurses invested in social justice practice work towards distributing health benefits with intentions of promoting equality. Exploration of oppressive forces such as racism, classism and sexism toward creating stability between populations with diverse characteristics is a central goal of social justice work (Boutain, 2005; Subramanian et al., 2003). Public health nursing is guided by this conceptualization as well as the notion of resources needing to be distributed fairly (CHNC, 2009). For example, Aston (2008) discusses the distribution of power between PHNs and mothers needing care in the community. Aston (2008) describes how PHNs focus on maternal agency, which is the understanding that mothers are sources of knowledge and have capacity to make informed choices. Awareness of where power lies within the care provider relationship has social justice intentions. However, PHNs also have capacity to understand broader influences of hegemonic power that lie in broader structures and influence health experience. Browne et al.’s (2010) findings allude to this capacity where PHNs locate structural inequities in their quest for families to achieve healthy living. Rather than pathologizing risks within a family’s experience of addiction and poor family support, PHNs locate influences of poverty and isolation as broad determinants needing attention. As a result, underlying intentions of social justice where all humans deserve health services in order to live in dignity inform PHN practice with non-judgemental inclusiveness. This practice leads PHN focus away from individualized behaviours to understand what influencers are shaping a family’s health. While social justice is at the core of public health nursing, it also overarches concepts such as human rights, ethics and equity.

Health equity has been a goal of Canada's public health sector since the development of the 1986 Ottawa Charter for Health Promotion (Pauly et al., 2013). Rooted in addressing what determines health equity, public health nursing is firmly committed to equity promotion (CPHA, 2010; CHNC, 2009; Pauly et al., 2017). However, recent public health nursing scholars have found that equity is understood in various ways and needs clarification (Cusack et al. 2017; Pauly et al., 2017). In fact, most provincial and regional senior public health decision makers in Pauly et al.'s (2017) study understood equity as how individuals access SDoH, thus reflecting continued individualistic approaches to health. As a result, Pauly et al. (2017) advised the need for enhanced political action at organizational and institutional levels in order to understand health equity as a social justice issue. It can be purported that social justice seems to have been forgotten in the race towards understanding equity. WHO (2018c) implicitly alludes to social justice stating "equity is the absence of avoidable or remediable differences among groups of people,". Within nursing, the social justice mandate is more explicit. For example, the International Council of Nurses (ICN) (2012) consistently focus on equity as a concept connected to social justice within their code of ethics. The intersecting nature of equity and social justice is thus implied and encouraged. The CPHA (2010) provide the public health nursing stance stating equity is centering health and well-being resource distribution around populations' needs. Thus, the principle of equity informs PHNs to focus attention on understanding needs of complex populations along with understanding distal forces that shape how health services are provided. For example, in exploring how equity is practiced among PHNs, Almond and Lathlean (2011) found that although PHNs aimed to provide equitable practice during postnatal screenings through relying on task-specific policies, these policies did not provide guidance on cultural competency. In effect, inequity was perpetuated by policies being focused on individualistic principles of egalitarianism

where all populations need to be treated equally despite having uniquely complex needs. Therefore, in this exemplar, although policies PHNs were driven by attempted equity-orientation, a gap was present in understanding population diversity (Almond & Lathlean, 2011). This disconnect can be addressed through PHN work. PHNs have the unique opportunity to understand how distal forces are in alignment (or not) with the needs of populations they work with. Consequently, the need for policymakers to understand PHN perspectives is critical.

While informing practice, principles such as social justice and equity are also supported by the Canadian Nurses Association through the code of ethics and policy briefings as well as by core Canadian public health nursing competencies. These include advocating for reducing inequity through legislative and policy developments, enhancing access to health and recognizing how determinants of health influence population groups (Community Health Nurses of Canada [CHNC], 2009). Overarching principles of social justice and equity guide public health nursing which is likely why PHNs have the capacity to naturally take up population health approaches (Canadian Public Health Association, 2010; CHNC, 2009; Pauly et al., 2017). PHNs have the unique opportunity to understand how distal forces are in alignment (or not) with the needs of populations they work with. Such forces include textual influences such as organizational, provincial and national policies. They also include ideologies that shape decision-making and societal thinking such as individualism, capitalism and racism. Understanding public health and PHN perspectives is thus critical to engage with the complex experiences of populations that are recurrently marginalized.

Unfortunately, value of the PHN voice and role has been historically and more recently eroded thus stifling PHN potential (Keller et al., 2011; Marcellus & Shahram, 2017; Pauly et al., 2017; Schofield et al., 2011). With political undermining of public health as a

health promotion facilitator and with health reforms continuously focused on centralizing public health services and chronically funneling funds into acute care (Guyon et al., 2017), generation of new and practical knowledge demonstrating how PHNs attend to health inequity is much needed (Schofield et al., 2011). Despite the slow and steady depreciation of their role, PHNs continue to demonstrate strong advocacy skills in enhancing the rights and elevating the voices of those historically rendered muted by unjust policies (Falk-Rafael & Betker, 2012; Schofield et al., 2011). For example in Falk-Rafael and Betker's (2012) study of public health nurses experiences described feelings of urgency to engage in political advocacy toward disrupting impacts of homelessness on health. Cathy Crowe is an example of a public health nurse who has confronted policy-makers for injustices located within intersections of poverty and housing (Crowe, 2019). As a homelessness activist, she has channelled her passion for public health nursing toward changing policies that have pushed socioeconomically disadvantaged populations further into margins of poverty and exclusion. Advocacy through professional associations is another example of engaging with unjust policies. In 2012, the Registered Nurses Association of Ontario (RNAO) engaged with over 900 nurses across Canada to refute harmful reforms to the Interim Federal Health Program Policy which drives healthcare provision among forcibly displaced groups. An open letter was written by the RNAO to Prime Minister Stephen Harper imploring all leaders across political parties to collaborate toward correcting inhumane policy decisions targeting forcibly displaced populations who arrive from contexts of pre-migration trauma and violence. The outcry paid off and amendments were made to protect certain refugee groups from health-care coverage cutbacks (Di Costanzo, 2012). While political advocacy and awareness of political and economic influences on the marginalization of populations such as forcibly displaced groups has evolved into more explicit guidance within nursing texts (Falk-Rafael &

Betker, 2012), there remains underlying ideologies that continue to constrain activism efforts among nurses. Neoliberalism is one such ideology that is prevalently identified in the literature as spawning barriers to social justice activism (Cohen & Marshall, 2017; Duncan et al., 2015; Falk-Rafael & Betker, 2012). Defined as a philosophy, or a way of thinking, neoliberalism is entrenched in pillars of individualism, capitalism and managerialism where free-market economics and efficiency models reign over decision-making (Browne, 2001; Duncan et al., 2015). Buck-McFadyen and MacDonnell (2017) identified neoliberalist thinking as driving nurse educators across practice and academia toward efficiency models of practice rather than social-justice oriented service provision. The authors claim focus has perpetually centered on fiscal cutbacks, increased workloads and narrowing of practice scopes rather than understanding how nurses can engage with political will. However, I contend in this dissertation that nursing, specifically public health nursing, is rooted in social justice and needs to be dissected to reveal the continued efforts toward population health. Demonstrating examples of how political advocacy occurs within nursing is thus a critical contribution to re-orienting and shaping nursing education and practice. The need to magnify skills and work demonstrating the capacity of public health nursing within a health system that perpetually focuses neoliberal values is one way to achieve this.

Immersed in the community health context, PHNs uniquely practice within the intersections of nursing and public health disciplines through engagement with population health competencies. Terms that allude to population health, such as *upstream thinking*, have been used within healthcare discourse and are not new to nursing (MacDonald et al., 2013). In fact, examples of such thinking can be traced back to the early 20th century where nurses were deployed into communities to address appalling living conditions among populations living in poverty (Edwards, 2009). In working with such communities, these PHNs were

exposed to the harsh realities of how class differential influenced health experiences. Consequently, PHN competencies include appreciation and engagement with intersecting individual and population-level health determinants (CHNC, 2009; MacDonald et al., 2013). Examples of individual determinants include personal health practices and individual coping skills which appreciate unique cultural factors (MacDonald et al., 2013). Broader social determinants of health-oriented influences are also valued in the population health approach and include socioeconomic environments and political landscape (MacDonald et al., 2013; Reutter & Kushner, 2010). Developing and acting on health equity initiatives that engage with determinants of health impacting complex populations have been long-standing competencies PHNs lean on (Cusack et al., 2017; Keller, et al., 2011). Shaped to work interweavingly with macro, meso and micro determinants of health, PHNs are well-situated to address inequitable provisions of health among maternal refugee women. In this dissertation maternal refugee women are defined as women who are experiencing maternal circumstances while also categorized as refugees by Canadian law. Maternal circumstances include the experience of pregnancy, childbirth and postpartum (WHO, 2018d).

Maternal Refugee Women

Before examining the Canadian context of forcibly displacement and women who are experiencing maternal health and well-being, the concept of forcible displacement needs clear definition. Drawing on Racine and Lu (2015), forced migration includes situational displacement due to varying historical and political origins. Psychological stress, uncertainty, instability, trauma and violence taint the experience of forced migration. Refugees are located within forced migrant groups as are asylum seekers and undocumented migrants. The category of refugee is primarily focused on within my substantive research due to the small yet emerging body of knowledge within nursing that focuses on this population (Almond &

Lathlean, 2011; Drennan & Joseph, 2005; Floyd & Sakellariou, 2017; Guruge and Khanlou, 2004; Merry et al., 2011; Racine & Lu, 2015; Willey et al., 2018). Important to note is the conflation of refugee discourse with immigrant discourse has been called out as an issue perpetuating inequity within policy and practice (Greussing & Boomgaarden, 2017; UNHCR, 2016b). Understanding context on differences within migrant status categories can capture complexities faced by refugees. Those situated within various migrant statuses outside of the refugee category have more choice and freedom. The epistemology of being an immigrant is rooted in the social construction of being a newcomer with authorization to participate and integrate more seamlessly into the society they have chosen to reside in (Kaplan, 1996). Lack of choice and the forcible nature of leaving home countries are some of the most notable differences between refugee and migrant discourse. The refugee experience involves compounded complex issues of uncertainty, loss, and fragmentation of family units. From a geographical perspective, the meaning of refugee is connected to transnational discourse where displacement from the borders of one's nation occurs due to violence or persecution (Hyndman & Walton-Roberts, 1999). The onto-epistemological assumptions of displacing into being a 'refugee' points to being forced into an identity that overrides their former senses of self. For example, with notions of family and social support being central identity contributors, profound experiences of family fragmentation and raising children in Canada undermines maternal refugee identity and mental well-being (Hajdukowski-Ahmed et al., 2009).

Canada participates in global assistance of sheltering displaced populations and has welcomed over 700,000 refugees in the past 40 years (UNHCR, 2019). Guiding Canada's role within the landscape of global forced displacement, are policies full of promise to protect persecuted populations (Government of Canada, 2019). However, a closer examination of

these policies reveals a turbulent history involving decreased healthcare coverage and diminished access to health needs among refugee women (Kandasamy et al., 2014). Although Canada is applauded for its focus on health promotion, especially through the Ottawa Charter for Health Promotion that aims at reducing disparity and enhancing equity in health (Government of Canada, 2017), research on immigrant and refugee health shows a complex intersecting system fraught with inequity. For example, Antonipillai et al.'s (2017) stakeholder analysis of perceptions on policy reforms impacting healthcare access among refugees revealed maternal refugee women being burdened with exorbitant costs for receiving emergency healthcare. This finding is supported by Wahoush (2009) who found refugee mothers faced financial and knowledge barriers when accessing healthcare. Additionally, Antonipillai et al. (2017) found a lack of knowledge among healthcare providers regarding refugee health policy as well as paucity of healthcare provider engagement in shaping refugee health policy.

However, issues embedded within broader systems seem to contribute to inaccessibility and knowledge gaps within service provision. Oxman-Martinez et al. (2005) for example highlight national immigration and health policies as being central to disadvantaging women based on government-allocated immigration category. The authors agree with the need to examine national policies to understand where inequities are located. Categorization of refugees occurs as part of Canada's refugee determination system. Conceptualized in 1989, this system has been revered for its reputable model of fair adjudication (Amnesty International, 2018). However, tangled within Canada's determination system are a set of classifications centered on ensuring national security (Library of Parliament, 2011) that drive processes of access to healthcare among refugees.

Refugees are therefore subjected to interviews and screening processes post-migration to determine allocation into one of the following categories: Government Assisted Refugee, Privately Sponsored Refugee, Joint Assistance Sponsorship, or Blended Visa Office-Referred (UNHCR, 2018c). Although each category attends to sociopolitical and socioeconomic circumstances of each refugee, annual resettlement target ranges set by Canada's Minister of Immigration, Refugees, and Citizenship also shapes the determination process. Provincial governments have input on these ranges before numbers are agreed upon. This example of refugees' fates being decided by target numbers politically shaped by provincial priorities supports McKeary & Newbold's (2010) claim of the Canadian system being unfit to support equitable healthcare delivery to an ever-growing refugee population. Newbold et al. (2013) further support this claim in their findings where women are perpetually marginalized by structural barriers rooted within migrant status. Situated within the context of women are mothering women, also described within the literature as women experiencing maternal health.

Defined by the World Health Organization (2018), maternal health is the experience of pregnancy, childbirth and postpartum. Maternal health outcomes among refugees living in Canada include higher rates of HIV, limited prenatal care, poor social support, abuse, low birth-weight infants (< 2500g) and higher caesarean section rates (Kandasamy et al., 2014). Health outcomes also include mental health issues. Over the last 10 years, researchers have identified mental health concerns as a significant challenge among the refugee maternal population (Alvi et al., 2012; Anderson et al., 2017; Clark, 2018; O'Mahony et al., 2012; O'Mahony et al., 2013; Stewart, et al., 2008; Sword et al., 2006; Vigod et al., 2017; Zelkowitz et al., 2004; Zelkowitz et al., 2008). These issues have included postpartum

depression, antenatal depression, anxiety, dissociative disorders, fear and post-traumatic stress disorder.

I chose to approach understanding maternal refugee women's health issues from the perspective of PHNs who practice within a population health framework. This holistic perspective provided an opportunity to engage with structural issues embedded within organizational, provincial, national and even global influences. From an intersectionality perspective, structural issues include processes of oppression that shape health experiences (Hankivsky & Cormier, 2009). These include, but are not restricted to classism and racism and their influence on social, political and economic decision-making that shape organizational and cultural contexts (CHNC, 2009; Mikkonen & Raphael, 2010).

Overview of Publication-Based Manuscript Chapters

This dissertation is composed of four manuscripts that demonstrate my substantial contribution to disciplines including nursing. Chapter 2 consists of the JBI protocol which was co-authored with a team of two additional reviewers: Dr. Lenora Marcellus, who is also my supervisor, and Dr. Diane Butcher, who has experience conducting a qualitative systematic review as part of her recently completed doctoral dissertation. Conducting JBI work within a review team is recommended in order to reduce bias and maintain the rigorous standards required (Aromataris & Munn, 2020). In addition, at least one of these team members need to be formally trained in the JBI systematic review approach (Aromataris & Munn, 2020). Fortunately, both team members working with me were trained and experienced JBI reviewers. With this JBI work being part of my dissertation, I worked independently and pursued advice and guidance from my team when questions arose. Moreover, the protocol went through multiple drafts to keep my team apprised and informed

of my work. This manuscript was published (Kassam et al., 2020a) and demonstrates development of a protocol employing JBI processes in preparation for conducting a systematic review of qualitative evidence. In preparing this protocol, I engaged the support of Dr. Carol Gordon, the University of Victoria JBI-trained librarian whose expertise helped shape an inclusive search strategy. The protocol also introduced readers to the current state of involuntary migration among maternal women as well as the need for understanding nursing perspectives. Despite my overarching dissertation focus on the PHN role, the perspectives of nurses in general was decided upon due to the limited number of articles that inquired into PHN experiences.

Chapter 3 of this dissertation is the JBI qualitative systematic review report. As described above, JBI work must be conducted within a team. However, as a PhD student, I worked independently and sought advice and guidance throughout the JBI process. Dr. Diane Butcher was the second reviewer for this manuscript. In my lead authorship role, I engaged with Diane multiple times using videoconferencing and email to discuss philosophical decision-making and methodological queries. Both Diane and my supervisor/third reviewer oversaw analysis and emerging of categories and synthesized findings. Audit trail tracking, engagement of online tools including Covidence¹ and the System for the Unified Management, Assessment and Review of Information (SUMARI)² (“Covidence systematic review software,” n.d.; Munn et al., 2018) questioning my thinking and visual mapping, were approaches included in my JBI analysis.

¹ Covidence is a web-based tool used within systematic reviews for screening and data extraction. It also allows authors to memo and track their decisions as well as import citations into reference managers.

² SUMARI is the System for the Unified Management, Assessment and Review of Information software employed by the Joanna Briggs Institute and used for systematic reviewing of evidence. This software facilitates the review process.

In Chapter 4 of this dissertation, I present my methodologically-centered manuscript. Leading my doctoral committee in writing this paper, I independently constructed and theorized the novel application of intersectionality as an analytical tool with CGT. This manuscript was published in the *International Journal of Qualitative Methodologies* in January 2020 (Kassam et al., 2020b). To further engage with this study design, I presented the notion of demonstrating congruence between intersectionality and CGT to the Grounded Theory Club (GTC). An interdisciplinary think-tank that facilitates learning through mentorship, GTC is based out of the University of Victoria, School of Nursing and provides opportunities to engage with scholars and students with various levels of experience. GTC has thus been a dynamic platform of mentorship and scholarly influence on my methodological thinking and growth. Engaging with writing this manuscript enhanced my own methodological conceptualization and served as a foundational stepping stone to implementing my research study.

Chapter 5 consists of my fourth dissertation manuscript focused on the substantive research conducted with PHNs. This constructivist grounded theory using intersectionality as an analytical tool generated a mid-range theory describing processes used by PHNs within their work with mothering refugee women in the community. The findings are presented as a manuscript prepared for publication within the *Qualitative Health Research* journal pending committee approval.

The development of these chapters was an iterative journey comprised of intersecting processes. For example, the historical and philosophical underpinnings were mapped out within initial stages of my JBI and CGT inquiries, however these underpinnings were referred to continuously to inform analysis and findings. Additionally, my thinking was journaled during analysis to capture discussion points I wanted to highlight within my manuscripts.

Journal entries were also tied into articles that surfaced during my JBI data extraction process along with my continuous engagement with related literature. To further demonstrate my conceptualizations of methodologies used within this dissertation, I will now take a deeper dive into how I pursued and approached each manuscript.

Systematic Review Manuscripts

My first and second manuscripts (see Chapters 2 and 3) include a JBI qualitative systematic review protocol and the subsequent systematic review report that addressed the following question: *What are the experiences of nurses caring for maternal immigrant and refugee women?* This review identified, critically appraised, and synthesized current knowledge pertaining to this question. Although the JBI methods are philosophically located within the landscape of post-positivism, the history of JBI stemming from the need for enhancing generation and uptake of evidence into the nursing discipline along with the vision of improving global health and collaboration drew me to engage with this methodology (JBI, 2016; Jordan, et al., 2006). Choosing to pursue a systematic review also reflected the influence of Dahnke and Dreher's (2016) call to address a widening chasm between research and practice. Many factors influencing this chasm were discussed by the authors, however they highlighted Risjord's (2010) conceptualization of theory-practice gaps which stimulated my own questioning. *How could my doctoral studies contribute to the need for generating knowledge for the sake of nursing practice?* I realized through such questioning that a pragmatic methodology summarizing current knowledge into a practical format for uptake into policy and practice would be my attempt at bridging the research-practice gap many nursing philosophers have highlighted (Dahnke & Dreher, 2016; Risjord, 2010; Thorne, 2013). Engaging with nursing science to summarize the role of care provision from a nursing perspective as well as articulating nursing knowledge employed globally to address the

complexities faced by mothering women who have been forcibly displaced were additional implications that drew me to using the JBI methodology.

Joanna Briggs Institute Methodological Overview. Integration of research to inform health sciences and healthcare decision-making holds promise for safe and quality care provision (Gopalakrishnan & Ganeshkumar, 2013; Polit & Beck, 2017). With substantial growth in health care literature over the past few decades, the quest among healthcare systems for gathering and summarizing the best evidence has increased (Evans & Pearson, 2001; Polit & Beck, 2017). Conducting a literature review is an approach that has potential for mobilizing this evidence. With health systems changing rapidly, literature reviews have been enhanced over time to include practical strategies for practitioners, educators, and policy-makers to immediately apply and create evidence-based change. Systematic reviews are situated within the family of literature reviews and are distinct in guiding researchers through processes of protocol and review development. Protocols are essentially like recipes with explicit steps for researchers to gather, analyze and synthesize data for their systematic review (Polit & Beck, 2017; Lockwood et al., 2020). Structurally built into the protocol and systematic review are processes intended to reduce bias and subjectivity. Systematic reviews are thereby viewed within the literature as a more disciplined and rigorous approach to supporting and informing policy and practice (Bartolucci & Hillegass, 2010; Hannes et al., 2013; Hannes, et al., 2018; Torrance, 2018).

Criticisms toward systematic reviews exist. Bartolucci and Hillegass (2010) outline ‘real world’ issues such as funding, lack of relevant studies related to the research question and lack of human resources to carry out a review that can impede timely execution of the systematic review methodology. Moreover, although processes exist to limit subjectivity, prematurely excluding articles based on inadequate reporting or appraisal can still occur

creating publication bias (Sandelowski & Barroso, 2003). More recently, Finfgeld-Connett (2014) found that systematic reviews of qualitative evidence resulting in meta-synthesis inquiries often generate isolated findings consisting of raw data and coding rather than integrating findings into current bodies of knowledge. Herber and Barroso (2020) equate such limitations to the proliferation of systematic review approaches. However, systematic reviews continue to exemplify a successful approach to generation of robust findings (Sandelowski & Barroso, 2007; Herber & Barroso, 2020).

There are many approaches to this methodology that consequently result in generating varying forms of knowledge (Polit & Beck, 2017; Hannes & Lockwood, 2012; Sandelowski & Barroso, 2007). While these variations are directly linked to the philosophical underpinnings each methodology assumes, how researchers philosophically approach these methodologies also impact generation of knowledge. In this dissertation, I chose to use the JBI methodology for its historical and philosophical foundations and global vision of informing policy and practice (JBI, 2016). To better understand findings generated within the JBI systematic review conducted as part of this dissertation, I will outline the historical foundations and philosophical situatedness JBI is located within.

Historical and Philosophical Underpinnings. Reviewing literature to summarize findings into more accessible formats is not new. In fact, it has been a notion that can be traced back to the mid-1800s (Clarke, 2016). Rooted in the biomedical sciences, the importance of evidence was emphasized to better inform health services (Starr et al., 2009). Widely known for initiating movement towards the systematic review methodology, Scottish physician Archie Cochrane first drew attention to the lack of evidence-informed practice through arguing how the lack of evidence wastes resources and drives needless suffering (Jordan, et al., 2006). In alignment with his positivist approach to evidence, Cochrane also

privileged the random-controlled trial (RCT) methodology, calling it a ‘very beautiful technique’ that promotes effectiveness and efficiency (Jordan, et al., 2006). In fact, Cochrane highlighted findings generated through RCTs as better for using within the systematic review methodology. The very first systematic review was published in 1987, just prior to Cochrane passing away. It was during this time that the Cochrane Collaboration was formed (1993) and an evidence pyramid of hierarchy was developed to express differences in knowledge creation (Murad et al., 2016). Systematic reviews were placed at the top and findings generated through this methodology was privileged. Since the inception of this evidenced-based pyramid that has dominated the health science research world since the early 1990s, critiques have surfaced that primarily point to the resounding simplicity and reductionism embedded within. The complexity of health issues is one large issue that requires more flexibility when within research approaches (Abeyasinghe & Parkhurst, 2013; O’Donnell et al., 2017). With the intentions behind development of the systematic review methodology stemming from measuring the effectiveness and efficiencies of interventions, the evidence pyramid has been criticized as ignoring contextualities within complex, structural interventions that are not amenable to experimental methodologies. Health policies are thus open to being uninformed (or inappropriately informed) when reliance on evidence hierarchies are privileged (Abeyasinghe & Parkhurst, 2013).

While Cochrane was busy shedding light on the lack of evidence guiding health practice, a nurse in Britain, Alan Pearson, noticed that evidence-based collaborations were constructed to minimally focus on nursing knowledge (Jordan, et al., 2006). Pearson worked on a busy orthopedic hospital ward where rates of pressure sores were high. He turned to researching different treatments and selected the most effective intervention. In doing so, he went against status quo of resorting to peer-to-peer advice and/or opinion and realized the

lack of quality evidence within nursing practice (Jordan, et al., 2006). He also realized that RCTs were not the only type of evidence when it came to health issues that were complex. Pearson's quest for evidence-informed nursing practice led to the creation of the Joanna Briggs Institute (1996) which initially focused on effectiveness of interventions (Lisy, 2014). Positivism was the underlying philosophy adopted within the JBI methodology as the institute continued to develop its methodology to include varying forms of knowledge (ie: qualitative, text and opinion, etc.). Resulting from this philosophy was an orientation framed by critical realism and pragmatism. Within this onto-epistemology, truth is often seen as objective, and knowledge generated moves beyond theory production toward action-oriented recommendations (Hannes & Lockwood, 2011). Researchers employing JBI methodologies are thus conduits of knowledge rather than interpreters.

Standardization in the process of developing systematic reviews is an expectation of JBI researchers in order to meet the outcomes of rigorous, transparent and unbiased reviews (Aromataris & Munn, 2020). However, within the conduct of a review that synthesizes qualitative evidence, tension and debate exists pertaining to the degree of interpretation researchers assume during data analysis (Lockwood et al., 2020). For example, the iterative nature of data extraction and synthesis is made explicit by JBI, however the need for interpretation during meta-aggregation of qualitative data is less clear. Through this philosophical murkiness however, Lockwood, Munn & Porritt (2015) state, "qualitative synthesis is an interpretive process" (p. 180). As a result, it has been posited that the process of qualitative synthesis needs to align with the philosophical orientations of critical and interpretive paradigms (Lockwood, Munn & Porritt, 2015).

Through these ongoing philosophical tensions, inclusivity is minimally discussed as underpinning the JBI methodology. However, the mission and direction with which JBI

progresses toward has demonstrated such a philosophy. For example, Pearson's overarching mission when first establishing the JBI was to ensure collaboration extended globally rather than exclusively to the Australian context. This led to the establishment of JBI institutes worldwide that deliver ongoing development and training to enhance healthcare delivery. Additionally, the continuous expansion of varying forms of knowledge into the landscape of JBI systematic reviewing methodologies is an epistemological demonstration of harnessing diverse forms of understanding. This aligns with my own critical feminist situatedness and drew me toward JBI and employing a systematic review for this dissertation.

Methodological Manuscript

The methodology manuscript (see Chapter 4) was published within the International Journal of Qualitative Methods (Kassam et al., 2020b) and demonstrates congruency between CGT and intersectionality as an emergent critical social theory and an analytical tool. The foundations of this article stemmed from my directed studies course final assignment. In essence, this article proposed expanding on CGT by responding to two distinct calls: Olesen's (2007) call for clarity when assuming a critical feminist stance within application of a CGT methodology, and; Collins (2019) call for keeping intersectionality in motion through pursuing its theoretical possibilities as an analytical tool for generating social action. Thus, this manuscript established a novel and rigorous research design through demonstrating congruency between CGT and intersectionality and the potential for generating knowledge that resists inequity. This manuscript was the stepping stone to my substantive inquiry where I applied the proposed research design to generate a theory describing processes PHNs used to work with mothering refugee women.

Conceptualization of Constructivist Grounded Theory. CGT was built upon the ideas of two sociologists, Barney Glaser and Anselm Strauss. Developing their work in 1967,

Glaser and Strauss founded the Grounded Theory (GT) methodological platform. Intentions of GT included describing social phenomena by exploring human behavior (Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1998). Over time, significant philosophical turns in thinking resulted in three different strands of GT: Glaserian, Straussian and Charmaz's CGT. The 1990s marked the initiation of this GT evolutionary movement where constructivism was taken up by Strauss and his postdoctoral student, Juliet Corbin (Cisneros-Puebla, 2004; Mills, et al., 2006). Together they worked toward shaping Straussian GT as a distinct strand focusing on broader contextual influencers to social behavior. Meanwhile, Kathy Charmaz, a keen sociology student of Glaser and Strauss, paid heed to the reframing of GT and situated herself within fully appreciating the constructivist paradigm. All three strands of GT have differing philosophical foci, however symbolic interactionism and pragmatism were maintained as central pillars.

Philosophically underpinned by a relativist ontology, CGT is rooted in embracing multiple truths. Additionally, its constructivist epistemology accommodates for multiple social constructions. Situated within an array of qualitative methodologies, CGT fosters researchers to construct basic social processes shaped by multiple perspectives provided by participants and the researcher. Unique within the three GT strands, Charmaz integrates critical feminism thus extending intentions of GT to salute the constructive nature of theory formation and acknowledge the researcher influence on the research process. The resulting development of CGT is thus grounded in tenets focusing on reflexivity, complexity, variability and social justice (Charmaz, 2017; Charmaz, 2014; Charmaz, 2009; Kushner & Morrow, 2003; Mruck & Mey, 2007; Olesen, 2007). These four tenets resonate within my conceptualization of CGT and I expand on them more within my second dissertation manuscript focused on methodology and research design.

Symbolic Interactionism. Developed by Chicago School sociologists George Herbert Mead and Herbert Blumer, symbolic interactionism was conceptualized to understand how humans shape their senses of self and create meaning through social processes (Chenitz & Swanson, 1986; Charmaz, 2014). SI was developed from the ontological assumption that realities exist as shared symbolic meanings (Aldiabat & LeNavenec, 2011). Drawing on Milliken and Schreiber (2012), symbols are social representations humans use to communicate verbally and/or nonverbally. Language, for example, is an approach to verbally create symbols of what can be visualized and/or considered. Humans create meaning of symbols through social interactions. Symbolic meanings are constructed and become shared through social interaction processes (Blumer, 1969; Milliken & Schreiber, 2012). Thus, the concept of interaction and the complexity of human action and thinking are appreciated within SI.

The epistemology of knowledge being located within social interactions is extended to include human interpretation of meanings (Blumer, 1969; Aldiabat & LeNavenec, 2011). The process of humans internally communicating with themselves and deciphering how to understand symbols and/or how to direct action based on their unique understandings is the process of interpretation (Blumer, 1969; Aldiabat & LeNavenec, 2011; Charmaz, 2014).

Dewinian Pragmatism. In conceptualizing CGT for my substantive inquiry, I drew from Strauss's explanation of pragmatism as Dewinian pragmatism (MacDonald, 2001). This perspective originated in 1922 through Chicago School of Sociology scholars. John Dewey refined pragmatism with his instrumentalist intentions where the interplay of action and consequences of action were valued (Shalin, 1991; Plummer & Young, 2010). Interaction reflects the philosophy of pragmatism where reality is constructed through social processes which are in constant flux and knowledge is located within these constructions. It is

significant to note how the capacity to critique and disrupt status quo is central to pragmatist thinking (Charmaz, 2017; MacDonald, 2001). These intentions include magnifying inequities capturing changes in action of participants experiencing problematic health issues over time (Charmaz, 2017).

Engaging with Intersectionality. Within the evolution of CGT, Olesen (2007) advised researchers to clearly situate their critical feminist approach within their inquiries. Doing so would make theory construction more explicit and move beyond mere description toward enhancing articulation of reflexivity and data analysis (Benoliel, 1996; Olesen, 2007). This advice resonated as I attempted linking CGT with intersectionality. Situated within the landscape of critical feminism, intersectionality is rooted in second-wave feminism in the 1960s where the unilateral view of women's voices was challenged. Social locations that shaped women's experiences were recognized and included race, ethnicity, Indigeneity, sexual orientation and class. Thus, a distinct feature includes appreciating voices of ignored populations including black activists, feminist thinkers, Latina, LGBTQ and Indigenous scholars (Hankivsky, 2014; Collins & Bilge, 2016). The concept and language of intersectionality, however, came about much later in 1989 through central feminist thinkers including Kimberlé Crenshaw and Patricia Hill Collins.

Philosophical assumptions of intersectionality include humans being viewed as irreducible, complex beings (Collins, 1993; Crenshaw, 1991; Walby, 2009). This complexity addresses human experience intricacies where social locations are positioned and intermingle with broader structural forces (Collins, 2015; Collins, 2019; Hankivsky, 2014; Van Herk et al., 2011). Consequently, truth can be ascertained through understanding the interconnectedness social and the forces that shape experience. Intersectionality is epistemologically rooted in constructivism where social locations are products of societal

thinking. Human experiences are unique and contextually influenced. A notable assumption within intersectionality includes contexts being ridden with power imbalance. A consequence of this assumption is generating knowledge that reveals overlooked and oppressed social locations and structural forces embedded within the human experience. Describing societal oppressions as influenced by intersecting patterns of social locations is another core tenet of intersectionality (Collins, 1993; Collins & Bilge, 2016; McGibbon & McPherson, 2011).

Conceptualizing Intersectionality. Intentions of applying intersectionality within my dissertation included illuminating the facilitators and barriers embedded within PHN interactions with mothering refugee women. Articulating issues this population faced along with the sociopolitical and economic influencers to these issues were also aims of employing this critical social theory. However, intersectionality emerged at a point where uptake exploded into multiple approaches leading to threats of superficial application (Collins, 2019; Hankivsky & Jordan-Zachery, 2019). The need for practitioners to apply intersectionality within the crossroads of critical analysis and social action has been urgently advised in order to keep intersectionality from becoming a fleeting and passing trend (Collins, 2019). In my efforts to keep intersectionality in motion, and in my efforts to clearly articulate data analysis through a specific critical feminist lens, I further conceptualized intersectionality as an analytical tool. While minimal articulations of attempting to apply intersectionality as an analytical tool have been made, I engaged with the philosophical and central tenets of intersectionality to guide my analysis towards thinking intersectionally.

What does intersectional thinking mean? I drew on several developers of intersectionality to attempt conceptualizing my intersectional thinking within this dissertation including Crenshaw, Collins and Hankivsky. Collins' (2019) outlining of intersectional

thinking was tangible and pragmatic which aligned with my own philosophical foundations. She addresses intersectional thinking as a formulation of at least three approaches to analysis: metaphoric, heuristic and paradigmatic. For this dissertation, I focused on metaphoric and heuristic as most closely aligning with how I conceptualized intersectional thinking.

The idea of intersectionality as a metaphor is rooted in Crenshaw's process of what is often called in the literature as coining the notion of intersectionality where she visualized overlapping of systems perpetuating oppression (Collins, 2019; Guidroz & Berger, 2009). This visualization led to the metaphoric birth of the term *intersectionality*. Collins (2019) draws attention to the impact of metaphors as a way to facilitate understanding and stimulate the senses to draw attention to often-ignored or under represented ideas or domains. This allowance to imagine is also supported by Hall (1996) who linked metaphorical approaches to valuable analysis and fostering of social change. Thus, I used intersectional thinking as a metaphor to visually and linguistically analyze for linkages between social structures and ideologies that surface within data collected.

While intersectionality as an analytic tool using metaphor identifies what is happening within a social problem, the use of a heuristic approach analyzes how solutions to social problems can be constructed (Collins, 2019). Development of action strategies that fosters interrogation of current knowledge and encouraged new questions is an outcome of using intersectionality as a heuristic approach to analysis. The potential for disciplinary reform is what attracted me to this form of analysis due to the promise of inequity disruption and consideration of new conceptualizations of PHN work with mothering refugee women.

While Collins (2019) and Crenshaw were pillars of my conceptualization of intersectionality for this dissertation, Olena Hankivsky's focus on presence of power relations and inequities located structurally was also integrated (Hankivsky, 2012). This meant paying

attention to structural and contextual forces shaping the data and articulating the social locations participants raised. Analysis was thus approached with the assumption that oppressive processes were embedded and thereby perpetuating inequity.

Substantive Research Manuscript

My fourth manuscript (see Chapter 5) demonstrates my application and implementation of the study design discussed in chapter 4. The following question was explored using CGT with intersectionality as an analytical tool: *How do public health nurses support refugee mothers in the community?* During my concurrent data collection and analysis process, the basic social process of Creating Safe Relational Space emerged to address the problem of establishing trusting relationships with mothering refugee women while managing broader structural forces emerged. Underpinning the conceptualizing of this inquiry was the marriage of my passion for public health nursing with my practice concerns related to the complexities of health determinants faced by mothering women who have been forcibly displaced.

Grounded theory (GT) had been on my radar since having the opportunity within my first year of doctoral courses to listen to Dr. Rita Schreiber and Dr. Marjorie MacDonald describe their methodological experiences. I was intrigued by symbolic interactionism and pragmatism as philosophically underpinning GT along with the historical dissonance that occurred resulting in the evolution of distinct methodological branches (Aldiabat & LeNavenec, 2011; Charmaz, 2014; MacDonald, 2001; Stern & Covan, 2001). I was also struck by Dr. Schreiber's emphasis on the usefulness of GT which included expanding areas of research that have been understudied to benefit particular populations (Schreiber, 2001). This aligned very closely to the area I was interested in: public health nursing and the supportive work employed with maternal refugee women.

In continuing my exploration of methodologies, I found myself drawn to the flexibility of GT and the explicit situatedness of the researcher role within CGT (Charmaz, 2009, 2012; Clarke & Friese, 2007). Curiosity fuelled further pursuit of understanding CGT through attending the University of Victoria School of Nursing's GTC. As briefly discussed above, the GTC provided opportunities to dialogue my own thoughts and questions of how CGT would fit questions I had around PHNs work with mothering refugee women. In solidifying my methodological decision, I completed a directed studies course where I further explored CGT and discovered alignment with my own philosophical situatedness and a fittingness with my substantive area of inquiry.

Diving into the Dissertation Package

Before you move into the next few chapters of this dissertation, I would like to summarize the overarching aims described in this foreword. Importantly, I also would like to keep my philosophical orientation at the forefront of the work you are about to dive into. The aims of this publication-based dissertation package included situating the health of mothering women who have been forcibly displaced within the nursing discipline. More specifically, I focused my work on making the PHN role visible within a context of structural forces that have historically eroded and undermined the PHN discipline. Such forces have been identified as managerialism and efficiency paradigms that have pared PHN roles down to clinical tasks situated within organizational priorities and biomedical agendas (Cusack et al., 2017; Marcellus & Shahram, 2017; Pauly et al., 2017). Choosing to do a publication-based dissertation reflects my pragmatic underpinnings where I wanted to ensure my findings and learnings were shared and disseminated. This dissertation is ultimately guided philosophically by my relativist and constructivist underpinnings and steered by the critical feminist tenets of social justice and equity promotion.

The question that guided this dissertation was: *How do PHNs work with women who are mothering and managing the effects of their refugee status?* I approached this question using two distinct methodologies: a JBI systematic review of qualitative evidence and a CGT methodology that applied intersectionality as an analytical tool. To demonstrate my understandings of each methodology, I focused this foreword on how I conceptualized each approach through a historical and philosophical lens. In doing so, I acknowledged JBI's post-positivist underpinnings and described how JBI's pragmatic and globally inclusive philosophy made this methodology amenable to my research question. My systematic review of qualitative evidence looks at the broader discipline of nursing and synthesized the various ways nurses cared for immigrant and refugee mothering women. My CGT was a more focused approach that further honed in on the PHN role and the processes used in working with mothering women who were forcibly displaced.

Once you have read the upcoming chapters, I will conclude this dissertation with Chapter 6, the Afterword. Here I discuss the significance and limitations of the inquiries conducted as well as implications for nursing. I draw from a dissertation findings table that outlines the salient outcomes of my doctoral inquiries. A knowledge translation focus will also be included consisting of how findings generated will be further disseminated. This includes the building of a knowledge translation package of activities as well as further research intentions. This is the 'now what' portion of my dissertation. It is a description of how I plan to purposefully continue this doctoral journey after my oral defence. Intentions of this continued journey include engaging with stakeholders and knowledge users to spark thought and shed light on the role of PHNs and on the impact of the current state of public health nursing on mothering women who have been forcibly displaced.

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Chapter Two: Systematic Review of Qualitative Evidence Protocol

Kassam, S., Marcellus, L., & Butcher, D. (2020). Experiences of nurses caring for maternal immigrant and refugee women: a qualitative systematic review protocol. JBI Evidence Synthesis, 18(11), 2416–2424. <https://doi.org/10.11124/JBISRIR-D-19-00222>

Review title

Experiences of nurses caring for maternal immigrant and refugee women: a qualitative systematic review protocol

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Experiences of Nurses Caring for Maternal Immigrant and Refugee Women: A Qualitative Systematic Review Protocol

Abstract

Objective: This review will focus on studies inquiring into nurses working across diverse healthcare settings and their experiences of caring for immigrant and refugee women who are pregnant or mothering. Within this review, diverse terminologies used to conceptualize ‘nurse’, ‘immigrant’ and ‘refugee’ will also be captured.

Introduction: Involuntary immigrant and refugee women who are pregnant or mothering experience poorer health than non-displaced women. Nurses are pivotal in providing care to this population. Understanding nursing experiences can reveal structural barriers and facilitators to equitable care provision.

Inclusion criteria: Peer-reviewed, qualitative studies that include nurses working across diverse healthcare settings and providing care to involuntary immigrant and refugee maternal women will be considered. Studies where nurses are described as being educated within a basic and generalized nursing program and have been authorized by a regulatory organization to practice nursing in their country will be included.

Methods: Key information sources searched include CINAHL, MEDLINE, Google Scholar and PubMed. Limits placed on this search include qualitative studies with abstracts available and published in English. Search terms will be adapted for each information source. Study selection includes screening titles and abstracts by two independent reviewers against the inclusion criteria. These reviewers will then critically appraise for methodological quality and begin data extraction to understand experiences of nurses and diverse understandings of

‘nurse’, ‘immigrant’ and ‘refugee’. Synthesis includes assembling and categorizing findings on the basis of meaning similarity. A set of statements will thereby be generated representing this synthesis.

Systematic review PROSPERO registration number: CRD42019137922

Keywords: immigrant; maternal; migrant; nurse; refugee

Abstract word count: 242 words

Total manuscript word count: 2499 words

Introduction

Migration is a global priority affecting over 250 million people and their families.¹ Fueled by multiple forces including sociopolitical and economic complexities, migration has recently been taken up as a determinant of health.² The link between migration and health underpins international initiatives such as the United Nations Sustainable Development Goals (SDG).³ Implemented in 2015, the SDG blueprint maps out goals centered on enhancing the well-being of people around the world. Improving health and reducing inequity are among these goals to be addressed by the year 2030. Situating these goals within migration facilitated a call for an integration of migrant health needs across multisectoral, government policies.⁴ Establishing and building on a research agenda to inform migrant health policy and professional development has also been prioritized within the recent Global Consultation on Migration and Health held in Sri Lanka.^{3,5} Within this investment into researching migrant health, inquiring into how programs and policies influence health was also emphasized.³

To better understand this link between migration and health, the research team will draw on the International Organization of Migration's definition of 'migrant' or 'immigrant'. Both words are often used synonymously in migration discourse and refer to people who move across international borders from their habitual residence for voluntary or involuntary reasons.⁶ This review is focused on involuntary migration. Migrating involuntarily means a person is forced to move away from their habitual residence. Forcible displacement is driven by political and socioeconomic issues such as war and persecution. People forced into migrating are identified by the United Nations High Commissioner of Refugees [UNHCR] as internally displaced, asylum seekers or refugees.⁷ Global statistics reflect over 68 million people are forcibly displaced. Of this unprecedented number, over 3 million seek asylum and almost 30 million are refugees.⁷ These numbers are rising every year.

Immigrant and Refugee Maternal Women

Women represent half of the world's refugee population.^{7,8} Further exploring this statistic reveals most of these women are child-bearing age and are pregnant, mothering or both.⁹ The experience of health during pregnancy, childbirth and post-birth, is defined by the World Health Organization (WHO) as maternal health.¹⁰ Therefore, the concept of 'maternal women' is any woman experiencing maternal health. This review initially focused on the phenomenon of maternal health among forcibly displaced populations including refugees and asylum seekers. However, due to limited generation of studies, the broader concept of 'immigrant' was included in this review. Although preliminary search results demonstrated authors combining forcibly displaced groups, such as asylum seekers, within their inquiries into refugees and immigrants, it is important to note wide diversity in immigrant conceptualizations. These are influenced by factors including political context,

socioeconomic status and plurality in culture and language. As a result, this review focuses specifically on studies involving immigrant and refugee maternal women who have migrated involuntarily.

Maternal health experiences among immigrant and refugee women are poorer than non-displaced women. For example, immigrant and refugee women experience higher rates of the following health issues: HIV, limited prenatal care, poor social support, abuse, preterm birth, low birth-weight infants, stillbirths, maternal mental health concerns, caesarean sections and maternal mortality.^{11,12} These glaring inequities are widely recognized by prominent global organizations such as the WHO and the UNHCR. Moreover, current global development goals reflect the need to address disrupting disparities, promoting maternal health and understanding capacities of countries to manage disparate health issues.¹³

Understanding Nurses Perspectives

This review will consider studies that include nurses working across diverse healthcare settings and providing care to immigrant and refugee maternal women. Within this review, we draw on the International Council for Nurses (ICN) policies where nurses are defined as those who have been educated within a basic and generalized nursing program and have been authorized by a regulatory organization to practice nursing in their country.¹⁴ A large focus of current literature addresses health issues faced by immigrant and refugees. Although there is a limited focus on understanding experience of care provision through healthcare provider perspectives, some studies have attempted to understand nursing attitudes and experiences.^{15,16} With nurses being recognized as leaders and pivotal actors within interdisciplinary teams, exploring nursing experiences has the potential to reveal structural

facilitators and barriers to equitable care provision.^{17,18} Nurses are well-situated within healthcare systems to connect with immigrant and refugee women seeking maternal care. In fact, advocating for equity and social justice as well as facilitating care toward meeting the health needs of vulnerable populations are values central to the nursing discipline.¹⁹ Moreover, nursing has been declared as a discipline that can provide care to immigrant and refugee populations across varying healthcare contexts efficiently, effectively and equitably.¹⁷

With current literature focusing primarily around health outcomes, there is a paucity in systematic reviews of nursing perspectives related to immigrant and refugee maternal health. Appraising and synthesizing what is known about nurse perspectives on care provision is an upstream approach to understanding maternal health. O'Mahony and Clark²⁰ support this claim in their finding that further inquiry into nursing perspectives can highlight tensions between equity-oriented competencies and policies riddled with inequity. Therefore, critically exploring nursing experiences as a knowledge source has the potential to inform health systems and influence equitable care provision. Through this review, the research team also aims to understand what knowledge is missing related to providing nursing care to immigrant and refugee maternal women. In addition, diverse terminologies used to conceptualize the concepts of 'nurse', 'immigrant' and 'refugee' will also be captured.

A preliminary search of PROSPERO, MEDLINE, the Cochrane Database of Systematic Reviews and the *JBI Database of Systematic Reviews and Implementation Reports* was conducted and no current or underway systematic reviews on the topic were identified.

The objective of this systematic review is to identify and describe nursing experiences of care provided to immigrant and refugee maternal women across health care settings.

Review question

The question of this review is: what are the experiences of nurses providing care within various health care delivery contexts to immigrant and refugee mothers who are pregnant and/or mothering?

Inclusion criteria

Participants

This review will consider qualitative studies that include nurses providing care to immigrant and refugee maternal women in diverse healthcare settings. The specific immigrant populations nurses care for include maternal women who have involuntarily migrated due to forcible displacement and maternal immigrant women who are have low proficiency in the language of their new country, are ethnically/culturally diverse and live in poverty. The ICN definition of nurses will facilitate capturing the various conceptualizations and titles of nurses used in this review. Healthcare workers that fall outside of this definition will not be included in this review. The studies considered in this review will be qualitative methodologies focused on the experiences of these nurses.

Phenomena of interest

This review will consider studies that explore nurses' experiences of providing care to maternal immigrant and refugee women who are pregnant or mothering. Focus of this review is on nurses providing maternal healthcare among involuntary immigrants as well as refugees and asylum seekers. Studies exploring nurses caring for immigrants with low literacy levels, are ethnically/culturally diverse and live in poverty will also be considered.

Context

This review will consider studies that describe the experiences of nurses working in various healthcare delivery environments. All environments will be settings where maternal immigrant and refugee women receive care. These care settings are the context of this systematic review and can be situated in either rural or urban locations. In addition, care settings can range from acute care to community care environments. Examples of acute care settings include labor and delivery and emergency room units situated within a hospital. Public health centers, volunteer health centers, and a woman's home are examples of community care environments.

Types of studies

This review will consider studies that focus on qualitative data including, but not limited to, designs such as phenomenology, grounded theory, ethnography, action research and feminist research.

This review will consider interpretive studies that draw on the experiences of nurses working with immigrant and refugee maternal women including, but not limited to, designs such as phenomenology, grounded theory, ethnography, action research and feminist research

This review will consider critical studies that explore experiences of nurses providing care to immigrant and refugee maternal women including, but not limited to, designs such as action research and feminist research.

Studies published in peer-reviewed academic journals as well as unpublished and gray literature sources will be considered. Studies and study abstracts published in English will be

included. Study abstracts published in English will be captured within the data extraction tool and reported within the Summary of Findings. Management of these abstracts will not include translating full texts. However, the authors will summarize how many English-written abstracts were found. With this search not being a historical analysis, date limits will be set to search for sources published between the January, 2000 and December, 2019.

Methods

The proposed systematic review will be conducted in accordance with the Joanna Briggs Institute methodology for systematic reviews of qualitative evidence.²¹ This review has been registered with the Joanna Briggs Institute registry and the PROSPERO registry. The PROSPERO registration number is CRD42019137922.

Search strategy

The search strategy will aim to locate both published and unpublished studies including grey literature. As a result, press information and position statements are examples of unpublished data that will be included. A preliminary limited search of CINAHL, PsycInfo and MEDLINE was undertaken to identify articles regarding the topic of this review. In collaboration with a university research librarian, the text words contained in the titles and abstracts of relevant articles, and the index terms used to describe the articles were used to develop a preliminary search strategy for CINAHL, PsycInfo and MEDLINE. Details of the CINAHL search strategy and records retrieved are outlined in Appendix I. The search strategy, including all identified keywords through subject headings or medical subject headings (MeSH), and index terms, will be adapted for each information source. A second search using these identified keywords and index terms will be applied across all included

information sources. The third search will include screening for additional studies among the reference lists of all studies selected for critical appraisal.

Information sources

Databases to be searched within the online reference tool EBSCO host include CINAHL, PsycInfo, MEDLINE, PubMed, Web of Science, and Social Science Citation Index. Unpublished and gray literature sources to be searched include Google Scholar, ICN position statements and press information as well as WHO reports.

Study selection

Following the search, all identified citations will be collated and uploaded into EndNote X9.2 Desktop and duplicates removed. Titles and abstracts will then be screened by two independent reviewers for assessment against the inclusion criteria for the review. Potentially relevant studies will be retrieved in full and their citation details imported into the Joanna Briggs Institute System for the Unified Management, Assessment and Review of Information (JBI SUMARI) 2017 (Joanna Briggs Institute, Adelaide, Australia). The full text of selected citations will be assessed in detail against the inclusion criteria by two independent reviewers. Reasons for exclusion of full-text studies that do not meet the inclusion criteria will be recorded and reported in the systematic review. Any disagreements that arise between the reviewers at each stage of the study selection process will be resolved through discussion, or with a third reviewer. The results of the search will be reported in full in the final systematic review and presented in a Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) flow diagram.²²

Assessment of methodological quality

Eligible studies will be critically appraised by two independent reviewers for methodological quality using the standard Joanna Briggs Institute Critical Appraisal Checklist for Qualitative Research.²³ Any disagreements that arise between the reviewers will be resolved through discussion, or with a third reviewer. The results of the critical appraisal will be reported in narrative form and in tables and visual maps.

All studies, regardless of methodological quality results, will undergo data extraction and synthesis (where possible). Following appraisal, the primary and secondary reviewers will meet and review critical appraisal results. The third reviewer will assist in resolving any disagreements that may arise. Methodological quality will be discussed and visually displayed through a critical appraisal results table.

Data extraction

Data will be extracted from studies included in the review by two independent reviewers using an adapted Joanna Briggs Institute data extraction tool (see Appendix II). The purpose of more than one reviewer extracting data is to minimize errors. Adaptation will support capturing diverse understandings of the following concepts: ‘nurse’, ‘immigrant’ and ‘refugee’. The data extraction tool has also been modified to capture details regarding participants, populations being care for, healthcare context, geographical location, study methods and the phenomena of interest relevant to the review objective. This includes health care setting, terminology used to describe and identify nurse participants, as well as how mothers who are immigrants and refugees are described. Characteristics of immigrants that will be extracted include involuntary migrant status, literacy level, socioeconomic status and

ethnic/cultural location. Findings, and their illustrations, will be extracted and assigned a level of credibility. Any disagreements that arise between the reviewers will be resolved through discussion, or with a third reviewer.

Data synthesis

Qualitative research findings will, where possible, be pooled using JBI SUMARI with the meta-aggregation approach.^{24,25} This will involve the aggregation or synthesis of findings to generate a set of statements that represent that aggregation, through assembling and categorizing the findings on the basis of similarity in meaning. These categories will then be subjected to a synthesis in order to produce a single comprehensive set of synthesized findings that can be used as a basis for evidence-based practice. Where textual pooling is not possible the findings will be presented in narrative and visual forms. The process of synthesizing and finalizing findings and their accompanying descriptions will occur by consensus between authors. This process will include synthesis of how involuntary migration is described as well as contextual factors of maternal immigrant and refugee women including low literacy, living in poverty, and diverse ethnic/cultural background. Narrative syntheses of terminology used to describe nurse participants as well as health care contexts of care provision will also be included.

Assessing certainty in the findings

The final synthesized findings will be graded according to the ConQual approach for establishing confidence in the output of qualitative research synthesis and presented in a Summary of Findings.²⁶ The Summary of Findings includes the major elements of the review and details how the ConQual score is developed. Included in the Summary of Findings will

be the title, population, phenomena of interest and context for the specific review (see Appendix III). Each finding from the review will then be presented, along with the type of research informing it and an evaluation of dependability and credibility using Munn and colleague's²⁶ ranking system.

Acknowledgments

We would like to thank the University of Victoria School of Nursing for providing Joanna Brigg's Institute doctoral student funding for Comprehensive Systematic Review training.

We also acknowledge and thank the Queen's University Collaboration for Health Care Quality: JBI Centre of Excellence site in Kingston, Ontario for the systematic review training provided.

This project contributes toward a Ph.D. Nursing degree for the corresponding author, SK.

Funding

This review has received no funding.

Conflicts of interest

The authors declare no conflict of interest.

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Summary of Appended Materials

Appendix I: Search strategy

Database and name of platform used: CINAHL Complete (EBSCOhost)

Search conducted on: December, 2019

Search	Query	Records retrieved
#1 – refugee	(MH "Immigrants+") OR emigra* OR immigra* OR transient* OR migrant* OR refugee* OR (MH "Refugees") OR (MH "Transients and Migrants") OR MW "asylum seeking" OR "asylum seek*"	8, 356
#2 – nursing	nurs* OR (MH "Maternal Health Services+") OR MW health* services OR (MH "Maternal-Child Nursing+") OR (MH "Nurse Attitudes") OR (MH "Attitude of Health Personnel+") OR MW attitude*	96, 371
#3 – maternal	"expectant mother*" OR (MH "expectant Mothers") OR perinatal OR postnatal OR postpartum OR antenatal OR prenatal OR pregnan* OR infan* or MW mother* or mother*	65, 931
#4 – qualitative focus	(MH "Qualitative Studies+") OR (MH "Phenomenology") OR "qualitative" or experience* or perspective* or phenomenol* or ethnograph* or interview* or attitude* or thematic analysis or "mixed method*"	156, 679
#5 – combined	#1, #2, #3 AND #4	302
Limited to: peer reviewed academic journals and dissertations, full text, published between January, 2000 and December, 2019, English language, research article		

Appendix II: Data extraction instrument

Reviewer	
Title	
Author	
Year	
Journal	
Record Number	
Study Description	
Abstract only published in English?	<input type="checkbox"/> Yes <input type="checkbox"/> N/A
Methodology	
Methods Used	
Phenomena of Interest	
<ul style="list-style-type: none"> • Participants are nurses 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure Comments:
<ul style="list-style-type: none"> • Participants care for involuntary immigrants and/or refugee mothers 	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:
Other characteristics identified: literacy, socioeconomic status, ethnic/cultural minority	
Healthcare setting	

Geographical setting	
Concept Description	
Terminology used to identify: <ul style="list-style-type: none"> • Nurses • Involuntary Immigrants • Refugees 	
Other characteristics identified: literacy, socioeconomic status, ethnic/cultural minority	
Study Findings	
Key findings	
Implications	
Reviewer Comments	

Appendix III: Summary of findings

Study Title, Author, Year, Country	Source type ¹	Phenomena of interest and Methodology	Healthcare Setting	Terminology used to describe nurse participants	Terminology used to describe immigrants and refugees	Key Findings and Implications			
						Illustration	Unequivocal	Equivocal	Unsupported

¹Identify study as research, abstract only, or grey literature; specify type of grey literature as described by the International Conference on Grey Literature (<http://www.greylit.org/about>)

Chapter Three: Systematic Review of Qualitative Evidence Manuscript

Kassam, S., Butcher, D. & Marcellus, L. (submitted for journal review). Experiences of nurses caring for maternal immigrant and refugee women: a qualitative systematic review. JBI Evidence Synthesis.

Review title

Experiences of nurses caring for maternal immigrant and refugee women: a qualitative systematic review protocol

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2. Diane Butcher, Employment & Social Development Canada, Victoria, Canada
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Experiences of Nurses Caring for Maternal Immigrant and Refugee Women: A Qualitative Systematic Review

Abstract

Objective: The objective of this review was to identify, critically appraise and synthesize qualitative evidence on the experiences of nurses caring for forcibly displaced immigrant and refugee women who are pregnant or mothering. Understanding terminologies used to describe ‘nurse’, ‘immigrant’, and ‘refugee’ was a sub-objective captured within this review.

Introduction: Nurses are central to providing care to populations experiencing inequities. These populations include pregnant or mothering immigrant and refugee women who have migrated involuntarily. Most women within this population are ethnically diverse and often experience poverty and low literacy. This review is focused on the experiences of nurses providing care to these women.

Inclusion criteria: The authors of this review considered qualitative peer-reviewed studies published in academic journals between January 2000 and January 2021. Studies and study abstracts published in English that inquired into nurses providing care to pregnant and/or mothering immigrant and refugee women who have been involuntary displaced were included.

Methods: Information sources that were systematically searched for this review included: CINAHL Complete, PsycINFO, and PubMed. Final searches were conducted in January 2021 using language within database thesauruses such as CINAHL headings and MeSH terms as well as keywords related to qualitative inquires on experiences of nurses caring for immigrant and refugee mothers. Study selection was approached through two reviewers screening titles and abstracts that aligned with the inclusion criteria. Joanna Briggs Institute approaches were used for critical appraisal, data extraction and data synthesis.

Results: Twenty-three qualitative studies were included in this review. Qualitative methodologies within these studies included exploratory, multiple case study, inductive, ethnography, explanatory, interpretive descriptive, and grounded theory. Of the 23 studies included, 16 studies identified a total of 186 participants as being nurses. The remaining seven studies grouped nurses into multidisciplinary participant groups and did not explicitly specify the number of nurses involved. Eleven studies considered the sex of participants and three studies considered participant history of migration. One hundred and fifteen verbatim findings were pooled into four categories and aggregated into the following two synthesized findings: i) Engaging with cultural and linguistic diversity; and, ii) Tackling the health effects of forced migration on maternal women. Study quality was rated as moderate on ConQual scoring where dependability was rated as moderate and credibility was rated as high.

Conclusions: Nurses centered their care provision on women's cultural traditions and used creative strategies to address language barriers. The impact of precarious migrant status on women's health was recognized through experiential learning rather than organizational guidance. Nurses shaped their care provision around knowledge of complex health issues among immigrant and refugee women including social isolation, impacts of exposure to trauma and violence and diminished access to prenatal care due to limited health insurance and/or pre-migration contexts of conflict where access to health services were limited. Nurses drew on multiple sources of knowledge including clinical, relational and population health understandings in providing care to maternal immigrant and refugee women.

Systematic review registration number: CRD42019137922

Keywords: migrant; nurse; qualitative; refugee; women

Abstract word count: 481

Summary of Findings

Experiences of nurses caring for maternal immigrant and refugee women: a qualitative systematic review				
Bibliography: Kassam S, Butcher D, Marcellus L. Experiences of nurses caring for maternal immigrant and refugee women: a qualitative systematic review. JBI Evidence Synthesis 2021; under review				
Synthesized finding	Type of research	Dependability	Credibility	ConQual score
<p>Synthesized finding 1:</p> <p>Engaging with cultural and linguistic diversity</p> <p>Nurses acknowledged cultural differences among immigrant and refugee women and engaged with ways to integrate cultural awareness within care provision. Centering care around women’s conceptualizations of health was a predominant strategy identified by</p>	Qualitative	Downgraded 1 level* Moderate	High	Moderate

nurses that enhanced their experiences of delivering culturally sensitive care. This strategy was particularly helpful within nurses' experiences of engaging with mental health care delivery. Nurses also acknowledged how immigrant and refugee women rely on family members for health information. Nurses described women as being linguistically diverse which created communication barriers. Experiences with incorporating interpreters within care delivery were described as beneficial. However, diminished				
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<p>rapport with women was a limitation nurses expressed as hampering care provision. While some viewed the absence of interpreters as compromising care, using alternative communication approaches involving family or software applications such as web-based translation tools were also seen as ineffective. Nurses discussed alternate ways of overcoming language barriers which included visual aids, body language and the universal demonstration of caring.</p>				
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<p>Synthesized finding 2:</p> <p>Tackling the health effects of forced migration on maternal women</p> <p>Caring for immigrant and refugee women included witnessing impacts of migration on health and social integration. This included providing care that addressed disparities promoted by migrant policies. Nurses linked these disparities to women not seeking prenatal care and pushing women into further isolation. Harnessing their clinical, relational and population health knowledge, nurses voiced strategies that</p>	Qualitative	Downgraded 1 level* Moderate	High	Moderate
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<p>facilitated connecting immigrant and refugee women to social and health systems. The realities of providing such care was described by nurses as limited by professional and administrative capacities influenced by organizational constraints.</p>				
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* Downgraded one level due to the following dependability issues in included studies: 19 out of the 23 included studies had no statement locating the researcher culturally or theoretically and no acknowledgement of researcher influence on the research.

Introduction

Global fragility has created humanitarian crises including individuals and families being forced to leave their homes due to war, persecution and climate change. In the last 10 years, 100 million people have been forced to involuntarily migrate away from their homes worldwide.¹ Involuntary immigrants are defined within this review as people forced to leave their home countries due to political and socioeconomic issues such as war, climate change and/or persecution.^{1,2} Migrant status categorization includes being labelled as a ‘refugee’,

‘internally displaced’, and/or ‘stateless’, depending on the settlement country policies.¹ Half of the global involuntary immigrant population consists of women and girls.¹ The focus of this review is on women and girls of child-bearing age and are either pregnant or mothering.³ Involuntary migration journeys are fraught with risk where maternal women are often subjected to trauma and violence. These women seek safety within host and settlement countries and often require maternal health care. The World Health Organization (WHO)⁴ defines maternal health as the well-being of women who are experiencing pregnancy, birth, or post-birth. This definition informs this review in conceptualizing “maternal women” as women experiencing maternal health. The state of a woman’s maternal health is inextricably linked to their migration journeys and migration status. Involuntary immigrant maternal women experience higher rates of HIV, mortality, caesarean sections, mental health concerns, varying forms of abuse, limited prenatal care and poor social support.^{5,6} In addition, this population of maternal women experience cultural and linguistic barriers within their host and settlement countries. Involuntary immigrants are more disproportionately disadvantaged socioeconomically than voluntary immigrants and often live in impoverished conditions.^{7,8} Care provided to maternal women who are involuntary immigrants is therefore critical to ensure engagement with complex health issues and enhancement of health trajectories. Nurses are well-positioned across varying healthcare delivery environments to provide the necessary care to this population of maternal women. Within this review, nurses were defined as individuals educated within nursing programs and authorized by their country’s regulatory practice organizations.⁹ Nursing care provision was defined through drawing on International Council for Nurses [ICN] policies where health promotion, illness prevention, advocacy, research, education and participation in health system management and policy development are central.⁹ This definition also inclusively captures nurses working across a broad system of

healthcare contexts ranging from acute and chronic care to primary and community care settings.⁹

Within current literature, researchers have explored health care professional and nursing experiences of working with involuntary immigrant maternal women.¹⁰ Within many of these studies, nurses have been identified as part of interdisciplinary teams working collaboratively toward addressing multi-layered health issues.^{11,12} In addition, studies have also been conducted exploring barriers to care provision among nurses. These include cultural and linguistic barriers where lack of understanding language spoken and traditional practices were encountered by nurses.^{13,14} Understanding nurse experiences has been identified as critical to identifying barriers embedded within structural forces such as policies and practice directives.¹⁵ Multiple studies have been conducted highlighting adverse health outcomes and barriers faced by involuntary immigrants. Researchers have explored nurses' experiences of caring for involuntary immigrant maternal women, within a wide variety of disciplines including geography, epidemiology, population and public health, nursing, midwifery, women's, family and children's health, medicine, psychology, education and cultural anthropology. A lack of systematic reviews exploring nurse experiences of caring for involuntary immigrant maternal women was determined within our preliminary reviews of current literature. As a result, the objective of this review was to identify, appraise and synthesize qualitative evidence focused on nurse experiences with immigrant and refugee maternal women. A secondary objective was to capture terminologies used to conceptualize "nurse", "immigrant" and "refugee". This objective stemmed from the diverse country-dependent categorizations given to involuntary migrants^{1,2} as well as the broad range of contexts within which nurses provide care^{9,10,11} The secondary objective was to facilitate identifying where maternal immigrant and refugee women primarily received nursing care

services and how migrant status discourse impacts nurse's experiences of care provision. A resulting meta-aggregation of appraised evidence provided synthesized findings summarizing current knowledge.

A preliminary search of PROSPERO, MEDLINE, the Cochrane Database of Systematic Reviews and the *JBI Database of Systematic Reviews and Implementation Reports* was conducted in September 2019 and no current or underway systematic reviews on the topic were identified.

The overarching review objective was to identify and describe the experiences of nurses providing care to maternal immigrant and refugee women. Capturing diverse terminologies conceptualizing 'nurse', 'immigrant', and 'refugee' was also an objective of this review.

Review question(s)

The question of this review was: what are the experiences of nurses providing care within various health care delivery contexts to immigrant and refugee women who are pregnant and/or mothering? A sub-question providing further detail on population attributes included: What are the diverse terminologies used to conceptualize "nurse", "immigrant" and "refugee"?

Inclusion criteria

Participants

This review considered full-text, qualitative studies that included nurses involved in caring for pregnant and/or mothering immigrant and refugee women within diverse health care

settings. Drawing on ICN policies,⁹ nurses were defined as being educated within a generalized program and authorized to practice nursing in their country. Participants within this review were nurses working with immigrant and refugee women who involuntarily migrated and were pregnant and/or mothering. Studies that did not capture nurse voices in their findings and did not explicate involuntary migration backgrounds of maternal women being cared for were excluded. Studies that did not focus on maternal women's health care were also excluded.

Phenomena of interest

This review considered studies that explored the experiences of nurses providing care to immigrant and refugee women who were pregnant and/or mothering and had involuntarily migrated. Understanding the multiple ways care is provided globally by nurses to the unique needs of this culturally and linguistically diverse population was a central interest. Rather than focusing on singular aspects of caregiving, such as providing sexual and reproductive care, the general experience of care provision was addressed.

Context

This review considered studies that were conducted within various urban and rural health care delivery contexts. These included acute and community health care environments. Hospital units, community health clinics, antenatal and maternity clinics, physician offices and humanitarian settlements with clusters of densely populated refugee camps are examples of study settings where nurses cared for immigrant and refugee women who were pregnant and/or mothering.

Types of studies

This review considered studies that focused on peer reviewed qualitative data including, but not limited to, designs such as grounded theory, ethnography, case study and interpretive descriptive. For studies that used quantitative and qualitative approaches, only the qualitative data were extracted and analyzed.

Methods

This systematic review was conducted in accordance with the Joanna Briggs Institute methodology for systematic reviews of qualitative evidence.¹⁶ This review was conducted in accordance with an *a priori* protocol registered in PROSPERO (registration number: CRD42019137922).¹⁷

Search strategy

The search strategy aimed to locate primary studies and grey literature published in English between January 2000 and January 2021. This date range was selected because this review was not a historical analysis and preliminary searches revealed sources were published in 2002 and onward. A three-step search strategy was utilized in this review. First, an initial limited search of CINAHL, PsycInfo and MEDLINE was conducted in September 2019 followed by analysis of the text words contained in the title and abstract and the index terms used to describe the articles. A second search strategy was undertaken in January 2020 and included all identified keywords and index terms, and was adapted for each included information source. This second search strategy was updated in January 2021. The full search strategies are provided in Appendix I. The third search was screening the reference lists of all studies selected for critical appraisal for additional studies.

The following databases were searched: CINAHL, PsycInfo, MEDLINE, PubMed, Web of Science including Social Science Citation Index, and Google Scholar. The use of grey literature

in this review was to complement and support findings. A grey literature search strategy was devised using Google which targeted specific global nursing organization websites that contained position statements, reports and press information. Sources were located through keyword searches based on our database search strategies.

Study selection

Following the search, all identified citations were collated and uploaded into EndNote X9.2 (Clarivate Analytics, PA, USA) and Covidence (Veritas Health Innovation, Melbourne, Australia)¹⁸ and duplicates removed. Titles and abstracts were screened by two independent reviewers for assessment against the inclusion criteria for the review (SK, DB). Potentially relevant studies were retrieved in full and their citation details imported into the Joanna Briggs Institute System for the Unified Management, Assessment and Review of Information (JBI SUMARI; Joanna Briggs Institute, Adelaide, Australia).¹⁹ Full text studies that did not meet the inclusion criteria were excluded and reasons for their exclusion are provided in Appendix III. Any disagreements that arose between reviewers were resolved through discussion.

Assessment of methodological quality

Eligible studies were critically appraised by two independent reviewers for methodological quality using the standard Joanna Briggs Institute Critical Appraisal Checklist for Qualitative Research.²⁰ Any disagreements that arose between the reviewers were resolved through discussion. The third reviewer was available to assist with disagreements, but was not required.

After both independent reviewers completed selected study appraisal, the reviewers discussed each article and assigned scores. Differences in scores were reviewed through

returning to how each reviewer interpreted the appraisal tool question. Included in this process was turning to the manual outlining the JBI methodology for systematic reviews of qualitative evidence for clarification.¹⁶ Discussion on the philosophical situatedness of each reviewer also took place which informed inclusion and exclusion criteria. Although most studies did not address theoretical situatedness or researcher influence on research, adequate representation of participant voice and congruence between philosophical perspective as well as between methodology and the research process were fundamental criteria for excluding studies on the basis of methodological quality.

Data extraction

Qualitative data were extracted from studies included in the review by two independent reviewers using an adapted Joanna Briggs Institute data extraction tool (see Appendix II).¹⁷ The data extracted included specific details about the study methods, phenomena of interest, geographical setting, health care setting, characteristics describing immigrant and refugee women and terminologies used to describe concepts of nurse and immigrant/refugee. Findings were extracted as themes and/or subthemes as identified and interpreted by the author(s) of each study. Each finding was supported by an illustration which was an extracted verbatim study participant quote. A level of credibility was assigned for each finding: unequivocal (U) which means the finding is accompanied by an illustration that is undoubtedly associated with the finding and is not open to challenge; credible (C) which means the finding is accompanied by an illustration but lacks clear association with the finding; or not supported (NS) which is when a finding is not supported by data.²¹ All findings were found unequivocal within this review. With this review being a component of a doctoral dissertation, the data extraction process was completed independently. However, the second reviewer accessed extracted findings and provided consistent support and ongoing

feedback. To minimize errors during this process, definitions of each level of credibility were discussed between the two reviewers and ongoing dialogue occurred during data extraction and synthesis. Any disagreements that arose between the reviewers were resolved through discussion. A third reviewer was available to assist with this process, but was not needed.

Data synthesis

Qualitative research findings were identified and, where possible, pooled using JBI SUMARI with the meta-aggregation approach.²²⁻²⁴ This involved the aggregation or synthesis of 115 findings to generate a set of statements that represented that aggregation, through assembling the findings and categorizing these findings based on similarity in meaning. This process included listing all findings and grouping findings with similar meanings. Assigning category titles to groupings was the next analytical step that occurred iteratively through referring back to the review question and phenomena of interest as well as to the illustration of each finding. This analytical process occurred repeatedly using whiteboards, poster boards and cue cards to map findings visually and thoughtfully into a final set of categories. This same analytical process was used when subjecting categories to a synthesis in order to produce a single comprehensive set of synthesized findings that could be used as a basis for evidence-based practice. All findings included in this synthesis were unequivocal and credible. Meta-aggregation was the process of generating a synthesized finding which is an interpretive description of a grouping of categorized findings. With this review being part of the first reviewer's doctoral dissertation, the data synthesis process of grouping and categorizing findings was completed by the first reviewer and discussed with the second reviewer. Numerous discussions regarding analytical steps occurred between the first and second reviewer throughout the data extraction and synthesis processes through email and videoconferencing. A journal was also kept by the first reviewer to trace the decision-making

processes used during meta-aggregation.

Assessing confidence in the findings

The final synthesized findings were graded according to the ConQual approach for establishing confidence in the output of qualitative research synthesis and presented in a Summary of Findings.²³ The Summary of Findings included the major elements of the review and detailed how the ConQual score was developed. The title, population, phenomena of interest and context for this specific review are included in the table. Each synthesized finding from this review is presented, along with the type of research informing it, scores for dependability and credibility, and the overall ConQual score.

Results

Study inclusion

As illustrated in Figure 1, the search strategy conducted in January 2020 across all included information sources identified 4,079 papers. The search strategy was updated in January 2021 and two additional studies met inclusion criteria. With these additions, the total number of information sources identified was 4,081. After titles and abstracts were screened for eligibility and duplicates removed, 4,021 were excluded for being irrelevant to the phenomenon of interest and not meeting inclusion criteria. The 60 remaining articles were imported from EndNote X9.2 (Clarivate Analytics, PA, USA) to Covidence (Veritas Health Innovation, Melbourne, Australia)¹⁸ and screened for inclusion. Twenty-four papers did not meet inclusion criteria and were removed. The 36 remaining articles were imported from EndNote X9.2 (Clarivate Analytics, PA, USA) to Covidence (Veritas Health Innovation, Melbourne, Australia)¹⁸ and full-text screening was completed by the primary and secondary reviewer. Due to population, phenomena of interest and study designs not meeting inclusion criteria, 13 papers were excluded. See Appendix III for further exclusion details. The

remaining 23 studies were imported to JBI SUMARI for critical appraisal. Prior to appraisal, the reference lists of these papers were screened and no additional studies were identified as meeting inclusion criteria. Critical appraisal for methodological quality was conducted by the primary and secondary reviewers using the JBI Critical Appraisal Checklist for Qualitative Research.¹⁷ No further studies were excluded. Grey literature used within this review did not include unpublished studies. This decision was supported by Benzies et al.²⁵ who advise grey literature as adding little if study volume and quality are high. The use of grey literature as complementary and supportive is also advised within JBI and systematic review guidance.^{25,26} Therefore, grey literature was applied to reinforce review findings and included WHO press information and ICN position statements.²⁷⁻³¹

Methodological quality

Based on the results of the JBI Critical Appraisal Checklist for Qualitative Research,¹⁹ the included studies were deemed moderate by both the primary and secondary reviewers. Each study was scored on the ten questions of the checklist: twelve studies scored 8/10,^{13,14,32-41} seven studies scored 9/10,⁴²⁻⁴⁸ and four studies scored 10/10.^{10,49-51} The primary and secondary reviewers discussed each study where discrepancies were resolved through dialogue. Discussing standards for inclusion was central to resolutions made.

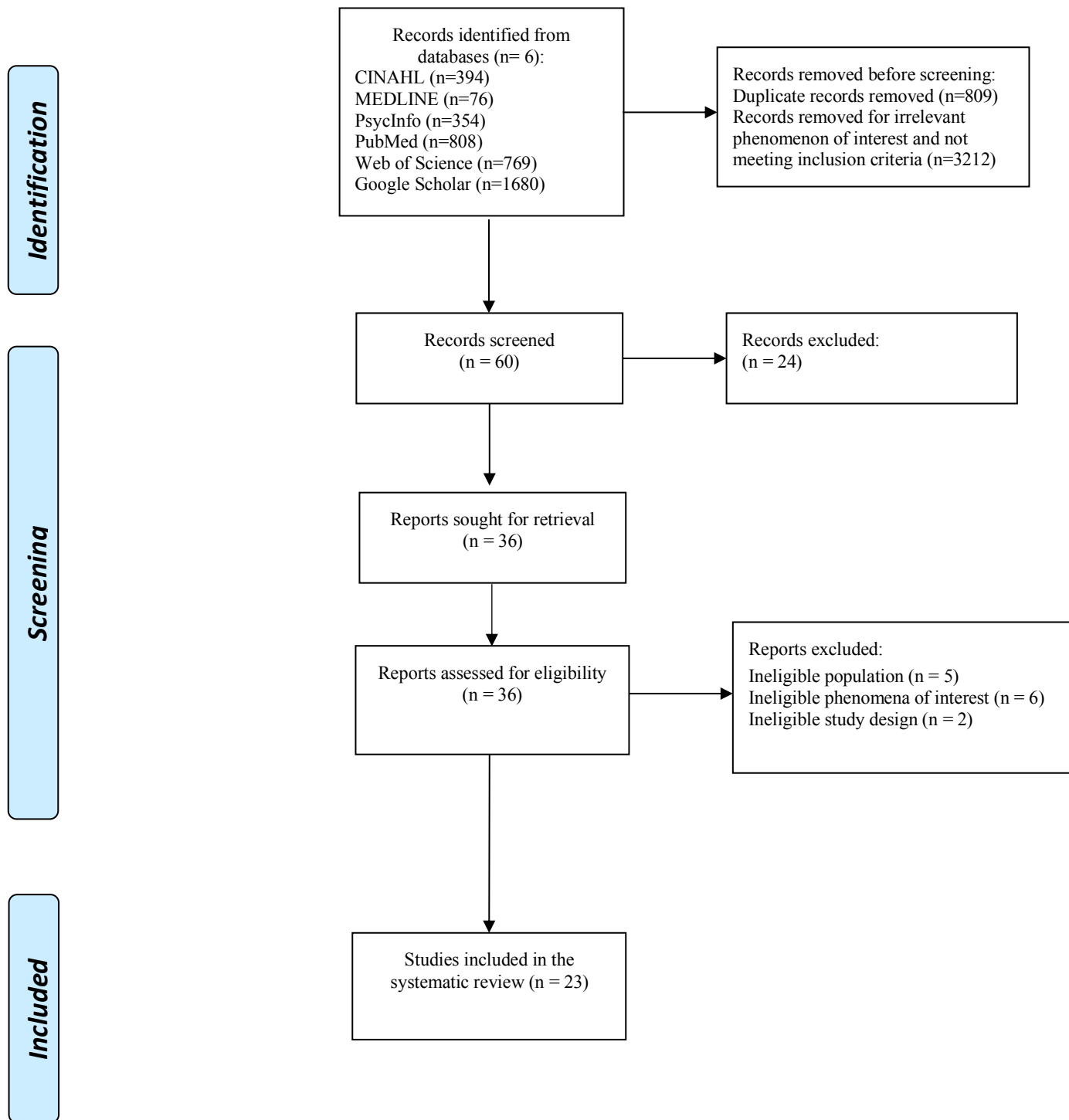


Figure 1: PRISMA flow diagram of search results and study selection and inclusion process⁵²

As illustrated in Table 1, 35% of studies met Q6 which asks: Is there a statement locating the researcher culturally or theoretically? In addition, 30% met Q7 which asks: Is the influence of the researcher on the research, and vice-versa, addressed? Studies not meeting these two questions was a notable a priori discussion between the primary and secondary reviewers. Reasons for some researchers not locating themselves within their inquiries or addressing their influence on their studies may have been their potential objectivist philosophical stances that assume natural separation of themselves from the data. To minimize exclusion of diverse epistemological perspectives, the primary and secondary reviewers decided to include papers that did not meet the Q6 and Q7 criteria questions. This decision aligned with the reviewers' critical feminist underpinnings that influenced an inclusive approach to this review. Q8 was the only eliminatory question as it represented capturing participant voices which was central to this review. All 23 studies met this appraisal question.

Table 1: Critical appraisal results of eligible studies

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Degni et al. ⁴²	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Drennan & Joseph ³²	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Ganann et al. ⁴³	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Jean-Baptiste et al. ¹³	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Kurth et al. ¹⁴	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Kynoe et al. ⁴⁸	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Leppala et al. ⁵⁰	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Lyberg et al. ⁴⁵	Y	Y	Y	Y	Y	Y	N	Y	Y	Y

Lyons et al. ⁴⁰	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Ng et al. ³³	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Nithianandan et al. ⁴⁶	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Origlia et al. ⁵¹	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Peláez et al. ¹⁰	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Reynolds & White ³⁶	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Rifai et al. ³⁸	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Riggs et al. ³⁴	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Sarker et al. ³⁷	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Seo ⁴¹	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Skoog et al. ³⁹	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Teng et al. ³⁵	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Willey et al. ⁴⁴	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Winn et al. ⁴⁹	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Yelland et al. ⁴⁷	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Total %	100	100	100	100	100	35	30	100	100	100

Y = Yes, N = No, U = Unclear; JBI Critical Appraisal Checklist for Qualitative Research Q1 = Is there congruity between the stated philosophical perspective and the research methodology?; Q2 = Is there congruity between the research methodology and the research question or objectives?; Q3 Is there congruity between the research methodology and the methods used to collect data?; Q4 = Is there congruity between the research methodology and the representation and analysis of data?; Q5 = Were those delivering treatment blind to treatment assignment?; Q6 = Is there a statement locating the researcher culturally or theoretically?; Q7 = Is the influence of the researcher on the research, and vice-versa, addressed?; Q8 = Are participants, and their voices, adequately represented?; Q9 = Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?; Q10 = Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

Characteristics of included studies

Data were extracted according to the following characteristics:

- Methodology used
- Participants (number of nurses included, gender, migration history, and race/ethnicity)

-
- Phenomena of interest
 - Characteristics of involuntary migrants
 - Healthcare setting
 - Country in which study was conducted
 - Terms used to describe nurse
 - Terms used to describe involuntary migrants

As seen in Appendix IV, all studies were approached using qualitative methods. However, one study was a mixed methods inquiry¹⁴ and six studies provided minimal details on which qualitative approach was assumed.^{34,36,37,47,50,51} The remainder of the studies in this review were described as using qualitative hermeneutic,⁴⁸ naturalistic descriptive,⁴² exploratory,^{13,32,33,51} interpretive descriptive,^{43,49} explanatory,³⁵ descriptive,⁴⁴ inductive,^{38,39} ethnography,⁴¹ descriptive exploratory,⁴⁵ grounded theory,⁴⁰ and case study.¹⁰ While all studies included understanding nurses' perspectives as part of their phenomena of interests, five studies focused explicitly on nurses.^{32,38,39,44,48} At least 186 nurses participated in the 23 studies included in this review. The exact number of nurses that participated in all 23 studies is unknown as seven studies did not specifically identify the number of nurses included within their multidisciplinary samples.^{35-37,40,41,43,47} Eleven studies articulated the sex of their participants and identified all of their participants as being female.^{10,14,33,35,39,42,43,45,49-51} Three studies briefly mentioned the race and/or ethnicity of their participants^{13,35,46} and three studies alluded to their participants' migration histories.^{32,35,43} Results of analysing geographical distribution of the reviewed studies indicated most studies taking place in Canada,^{10,33,35,43,49} and Australia.^{34,44,46,47} Several took place within varying parts of Europe including Finland,^{42,50} the United Kingdom,^{32,36} Switzerland,^{14,51} Sweden,^{38,39} Ireland,⁴⁰ and

Norway.^{45,48} One study was conducted in Bangladesh,³⁷ one was conducted in Thailand,⁴¹ and one was completed in the United States.¹³ Most studies took place within community health clinical settings.^{13,14,32,33,35,36,38,39,42,43,46,49,50} Four of these settings were specialized to target involuntary migrant populations.^{35,36,46,49} Other study settings included hospitals,^{10,40,41,48} a densely populated humanitarian settlement site (community of refugee camps),³⁷ and a university.⁴⁵ Four studies did not specify their study setting.^{34,37,44,51}

A broad range of terminologies were used to identify ‘nurse’ across the 23 studies appraised within this review. These included: psychiatric nurse,⁴² family planning nurse,⁴² maternity nurse,⁴² maternal and child health nurse,^{34,44,46} chronic disease nurse,⁴⁹ nursing-midwifery team,¹⁴ public health nurse,^{35,38,45,50} registered nurse,^{35,50} registered nurse with specialist training,³⁸ obstetric nurse,⁴¹ child health services nurse,³⁹ practical nurse,³⁵ labor and delivery nurse,⁴⁹ nurse,^{13,36,37,51} auxillary nurse,⁴⁰ nurse practitioner,³³ perinatal mental health nurse,⁴⁶ and neonatal intensive care unit nurse.⁴⁸ Three studies, all conducted in Australia, identified refugee health nurses^{34,46,47} who specifically cared for involuntary migrants. However, many studies in this review pooled nurses into general terms of maternity care professional,⁵⁰ health professional,^{10,33,36,47,51} service/healthcare provider,^{37,43,47,49} and health visitor.^{13,32}

Terms used to identify involuntary migrant groups also ranged. Four terms most frequently used were refugee,^{10,32,34,41-44,46,47,49-51} asylum seeker,^{14,32,36,39,40,42-44,46,51} migrant,^{10,39,40,45,48,51} and immigrant.^{10,13,33,35,38,39,42,43,45,48} Humanitarian migrant,^{34,44,47,50} undocumented immigrant,^{10,13} and newcomer^{35,43,50} were also used frequently. Infrequently used terms to identify involuntary migrants included undocumented foreigner,⁵¹ undocumented migrant,⁴¹ undocumented alien,⁴¹ non-citizen,⁴¹ non-citizen other,⁴¹ and

stateless people.⁴¹ One study used the term Forcibly Displaced Myanmar Nationals as coined by the Bangladesh government to indicate non-citizenship status of Rohingya refugees.³⁷

Studies included in this review described involuntary migrants predominantly as having low literacy skills^{10,13,14,33-36,38,40,41,43-51} and as being a cultural and ethnic minority.^{10,32-35,38,40-43,45-49} Involuntary migrants were also described as having socioeconomic issues,^{10,13,32,37,41,45,47} which included living in poverty^{10,32,37,41,45,47} and living in precarious housing developments.^{13,37,41,47} Characteristics of involuntary migrant women also included having experienced trauma, loss and violence within contexts of war and persecution.^{10,14,32,36,37,44,45,46,47,49} Five studies mentioned exposure to gender-based violence.^{14,32,36,37,47,49} Two studies described the dependency of maternal immigrant and refugee women on their spouses.^{35,38} Brief descriptions of maternal involuntary migrant women experiencing racism and discrimination were mentioned in four studies.^{10,32,40,44} One study's findings included strengths-based descriptions where involuntary migrant women were viewed as ready to learn and transition into mothering in a new country despite facing hardships of forced displacement.⁴¹ Other descriptors of maternal immigrant and refugee women within this review included experiencing isolation,^{35,36,38,41} having low education levels,^{42,45,49} and experiencing fear and uncertainty due to precarious migrant status.^{14,49,50} Appendix IV outlines further details of study characteristics.

Review findings

From the 23 studies included in this review, 115 findings were extracted that addressed the experiences of nurses caring for maternal immigrant and refugee women. Most studies within this review articulated the number of nurses who participated within their study samples.^{10,13,14,32-34,38,39,42,44-46,48-51} Seven studies did not explicate the number of nurses

involved in their studies and pooled them into multidisciplinary group participant samples.^{35-37,40,41,43,47} All findings were graded as “unequivocal” (U) as they were all supported by verbatim illustrations and therefore not open to challenge.

The 115 findings were aggregated into four categories based on similarity of meaning, concepts or ideas voiced within the illustrations. Meta-synthesis of these categories occurred through considering similarities in meaning across all 115 findings. This meta-synthesis process generated two synthesized findings: i) Engaging with cultural and linguistic diversity; and, ii) Tackling the health effects of forced migration on maternal women. Appendix V displays a meta-aggregation of the four categories with their associated findings and illustrations. Similarity of meaning informing each synthesized finding is included within these appendices. The following is a presentation of the two generated synthesized findings. Each synthesized finding is described followed by the respective categories.

Synthesized finding 1: Engaging with cultural and linguistic diversity

This synthesized finding was constructed through aggregation of two categories supported by 64 unequivocal findings (see Appendix V). Categories represent how nurses acknowledged cultural differences among immigrant and refugee women and engaged with ways to integrate cultural awareness within care provision. Centering care around women’s conceptualizations of health was a predominant strategy identified by nurses that enhanced their experiences of delivery culturally sensitive care. This strategy was particularly helpful within nurses’ experiences of engaging with mental health care delivery. Acknowledging how immigrant and refugee women rely on family members for health information was also voiced by nurses within their experiences of care provision. Nurses also described women as being linguistically diverse which created communication barriers. Experiences with incorporating interpreters within care delivery were described as beneficial. However,

diminished rapport with women was a limitation nurses expressed as hampering care provision. While some viewed the absence of interpreters as compromising care, using alternative communication approaches involving family or software applications such as web-based translation tools were also seen as ineffective. Nurses discussed alternate ways of overcoming language barriers which included body language and the universal demonstration of caring.

Category 1.1: Centering care around culture

This category was constructed from 29 findings where nurses described their experiences of integrating cultural sensitivity within care provision and pursuing ways to further their understanding of diverse cultures among immigrant and refugee women. Nurses were sensitive to ensuring immigrant and refugee maternal women felt they were cared for despite having ethnic and cultural differences. Employing cultural sensitivity was illustrated through looking beyond differences and listening. While nurses recognized differences in cultural traditions, they also expressed a desire to engage with understanding how culture affected women's maternal care practices. Centering care delivery around a woman's cultural preferences was described by nurses as an approach to integrating cultural awareness. This occurred by adapting care delivery protocols and policies to support cultural practices of maternal immigrant and refugee women. Examples of employing flexibility within care provision included inquiring into and integrating women's care practices within delivery of health information.

". . . I often ask them too 'What culturally would you do in your own country' so you've got, that my education level increases to, like for something like the safe sleeping you know what their norm is so then you can say 'Well, this is what, that's okay but in Australia you might do this a

bit differently because the weather's so much colder here than in Africa as well'. We wrap the babies . . . So find out what their normal is before trying to change it.," 44(p.3392)

When caring for women, nurses described privileging mother's belief systems over their own. This included being open to women's spiritual and cultural beliefs around maternal and infant well-being, infant loss and bereavement. Nurses described being open to learning new meanings of social practices to facilitate supportive relationships with immigrant and refugee maternal women. Nurses addressing maternal mental health issues valued this approach and found being open to new meaning promoted dialogue around issues women were not accustomed to speaking about.

Many nurses described how immigrant and refugee maternal women discussed mental health concerns as feelings rather than as a clinical diagnosis of depression or anxiety. Additionally, nurses described some women avoided mental health discussions for fear of being labelled as 'crazy'²⁷ for not feeling happiness during joyous events such as childbirth. Using screening tools such as the Edinburgh Postnatal Depression Scale were inadequate for addressing diverse cultural conceptualizations of mental health. Instead, women-led explorations facilitated nurses to learn about factors that shaped women's mental health and well-being which included food security and housing. Nurses described a woman-led approach fostered discovery of culturally appropriate words related to mental health. Nurses voiced how this approach promoted culturally-sensitive conversations and dialogue leading to further understanding of a woman's health concerns. Effects of using culturally sensitive language included discovering issues of post-traumatic syndrome and experiences of pre-migration trauma that impacted coping during pregnancies, ante-natal appointments and physical examinations.

In providing care, nurses acknowledged sociocultural influences such as family dynamics as shaping maternal immigrant and refugee women's traditional practices. Nurses described how family members such as mothers-in-law or husbands, were sources of health information for women. Some nurses voiced the need to integrate these family members into care provision activities. Fully understanding all nuances of particular cultures was voiced as being impractical. However, nurses described focusing care provision on heightening values of respect, trust and inclusivity.

Category 1.2: Communicating through language barriers

This category was constructed through 35 findings where nurses described language as a barrier within care provision and what strategies assisted in communicating health information across this barrier. Nurses empathized with maternal immigrant and refugee women in their need to sustain their identities while learning a new language and integrating into a new sociocultural environment. Partnering with other disciplines was a strategy nurses employed to reduce language and cultural barriers toward enhancing care. Examples of disciplines nurses collaborated with to address language barriers included psychologists, social workers and interpreters. Accessing translation services was described by nurses as both beneficial and limiting. Benefits of working with interpreters included nurses being able to communicate clearly with women. Channeling information through an interpreter provided nurses with a sense of security that health information was being understood. However, working with interpreters limited establishment of trusting relationships with women.

Nurses described additional limitations involving nurses needing to be sensitive to cultural dynamics between interpreters and women. Once nurses noticed any discomfort or mistrust of an interpreter, nurses would intervene and schedule a new appointment with a new interpreter. Another significant limitation for nurses in this review was the

inaccessibility of interpreters. The amount of time needed for nurses working in acute settings to find an interpreter was challenging. When interpreters were not available in these settings, ultrasounds, x-rays and blood tests were relied upon to visually communicate physical health issues among maternal immigrant and refugee women. Interpreter inaccessibility was also described as challenging within acute care contexts involving rapid paced care provision and use of technology foreign to most immigrant and refugee women.

“When you’re in the delivery and there’s an acute situation, and you’ve got to do a vacuum or the obstetrics, the obstetrician has to come in [...], sometimes there’s no time to go get the language line phone, and then be put on hold, having to have a back and forth conversation translated, back to do you understand what the risks are. So, that’s one of the barriers, it is the language in acute care,”^{49(p.6)}

Across healthcare settings, nurses discussed using visual aids as a creative solution to communicating when interpreter services were not available. Common language such as hand gestures and body language including smiles and nodding heads were used to facilitate communication within acute care facilities. Some nurses also described how words were not necessary “to see that someone cares for your child. The handling is quite universal.”^{48(p.2225)}

In the absence of interpreters, nurses described approaches such as Google Translate and interpretation through family members as inadequate and inappropriate ways to communicate across language barriers. Many nurses found providing care through a family member led to mistranslation where women end up not receiving the entirety of health information being provided. Mistranslation and misunderstanding information being provided was described by nurses as compromising confidentiality and quality of care. Maintaining confidentiality through ensuring issues including sexual and reproductive health assessments are conducted discreetly was emphasized by nurses. Nurses discouraged relying on family or

friends for translation to preserve women's confidentiality. In addition, nurses scrutinized professional conduct of interpreters through observance of competent interactions with mothers and adherence to commitments of privacy.

Synthesized finding 2: Tackling the health effects of forced migration on maternal women

This synthesized finding was constructed through aggregation of two categories supported by 51 unequivocal findings (see Appendix V). Caring for immigrant and refugee women included witnessing impacts of migration on health and social integration. This included providing care that addressed disparities promoted by migrant policies. Nurses linked these disparities to women not seeking prenatal care and pushing women into further isolation. Harnessing their clinical, relational and population health knowledge, nurses voiced strategies that facilitated connecting immigrant and refugee women to social and health systems. The realities of providing such care was described by nurses as limited by professional and administrative capacities influenced by organizational constraints.

Category 2.1: Seeing and acting on the impacts of migration on women's health

This category was supported by 16 unequivocal findings (see Appendix V) describing nurses' views on how migrant status impacted women's health and affected care provision. Nurses described ways to mitigate inequities fostered by migrant policies with focus on addressing social isolation as a health determinant hindered by limited access to social supports. While many nurses described receiving little formal training on deciphering varying migrant status groups, migrant status was seen by nurses as impacting women's broader health determinants. Housing instability and living in poverty were often witnessed by nurses where immigrant and refugee maternal women had inadequate access to food and clothing. Nurses

also recognized migrant policies as impacting receipt of fair and equitable care among maternal immigrant and refugee women.

"...if you don't have a Canadian status, well, you will have no rights at all, they have literally nothing, not even access to legal recourses because they cannot even claim for refugee status. These people, it's sad what I am going to say, but they just live in the shadows, in all possible senses!"^{10(p.5)}

Nurses observed migrant status as a barrier to accessing comprehensive health insurance which consequentially hindered access to health care supports. For example, nurses observed immigrant and refugee maternal women avoided seeking prenatal care due to unaffordability. Being ineligible for services addressing social isolation was also observed by nurses as an impact of migrant status.

While nurses understood how migrant status affected service eligibility, they also described social isolation as a predisposing factor to postnatal depression among immigrant and refugee women. Nurses voiced how caring for maternal immigrant and refugee women included addressing depression and anxiety stemming from precarious migrant status and migration away from family supports. Nurses were aware of the importance of addressing isolation especially among involuntary immigrant women who were forcibly separated from their communities. Specific to this separation was being detached from female support circles who provided essential care provision during women's experiences of maternal health. Care provision included spending time on understanding pre-migration experiences and geographical backgrounds. Bridging women to local community was a strategy nurses used to address lack of social support. Nurses centered their care on connecting women socially as well as to systems to healthcare provision.

Category 2.2: Harnessing nursing knowledge to orchestrate care

This category was supported by 35 unequivocal findings (see Appendix V) where nurses described themselves as harnessing their understandings of complex maternal health issues and health systems to meet the health needs of involuntary migrant women. These understandings fostered coordinating and connecting women to health and social systems with an overarching goal of facilitating community integration. Nurses also voiced how these care provision activities were constrained by organizational shortcomings.

Many nurses stated knowing all intricacies of health systems was challenging. However, they embraced their role which included providing clear information on finding a family doctor or midwife to provide antenatal, perinatal and postpartum care. In doing so, nurses found they had to start from the beginning as most maternal immigrant and refugee women had little understanding of how health needs were addressed in their host country. Many nurses described women's antenatal care as limited due to having diminished access to health services within war-torn countries. These women were thereby considered as having high-risk pregnancies and needing care pathways fitting to their complex needs. Nurses found they were among the first health providers contacted by immigrant and refugee women and provided a gateway for these women into the health system. Ensuring timely maternal follow-up and close monitoring due to limited pre-migration antenatal care was thus viewed as critical to nurses' care provision.

Nurses described their understandings of maternal health issues as significant to coordinating the appropriate care needed. Nurses faced multiple complex health issues among maternal immigrant and refugee women. One such complex issue involved exposure to trauma and violence. Nurses described pre-migration trauma and violence as contributing to discomfort among maternal immigrant and refugee women in conversing and receiving tests

related to sexual and reproductive health. While lack of comfort in knowing how to engage in women's experiences of trauma and violence was expressed by nurses, care provision centered on being sensitive and attentive to women's emotional well-being during clinical interactions. Nurses emphasized the need for establishing trusting relationships with women to foster disclosure of experiences of trauma and violence. Assurance of confidentiality and consistent emotional support were ways nurses established trust. However, nurses also reflected on being challenged by the distress they felt in listening to women's stories of pre-migration violence due to war and persecution.

Nurses voiced understandings of relational care as essential to provision of care. Maternal involuntary migrant women increased engagement with the health system when strong relationships were formed with nurses. Establishing trust was challenging with many women arriving from countries where public health systems were non-existent and government officials were feared. Anxiety related to dealing with government was acknowledged by nurses and mitigated through aiming for continuity of care and clarification of their role within the health system. Continuity of care was voiced as critical in providing relational care. However, service administration processes that deterred continuity of care were described as disruptive to developing therapeutic relationships between nurses and women and promoted disengagement of women from care provision.

Additional constraints described by nurses included lack of organizational commitment to enhancing clinical processes toward accommodating the additional time needed to provide care to women with multiple health issues. Without capacity to spend time and energy with this group of women who often experienced serious trauma-related mental health issues coupled with language and cultural barriers, nurses were left fatigued and exhausted.

“How much extra time do you need to allocate when you get ...a high...a positive? ... you need to have the capacity within your system to manage it if you've got someone who's suicidal... (ID 23; HP), ”^{46(p.6)}

Listening to atrocities of forced migration among women left nurses emotionally exhausted and traumatized. Receiving emotional support by informal sources such as peers was described as being a central need for nurses caring for immigrant and refugee women.

Discussion

This synthesis of qualitative evidence summarized 115 findings from 23 critically appraised studies into two synthesized findings that captured geographically variation and diverse care delivery contexts. The generated synthesized findings magnify the knowledge nurses use and how nurses enact healthcare provision when working with maternal immigrant and refugee women. Additionally, this review highlights how nurses drew primarily on experiential learning to understand complexities unique to forced migration among women. Awareness of these complexities can contribute to understanding how healthcare provision is being fostered and impeded by broader forces such as migration policy.

In this review, many nurses described how they engaged with diverse cultural practices and limited literacy skills. While some nurses voiced discomfort with understanding different cultural traditions,^{35,39,40} others embraced diversity through being open to new understandings of maternal health as well as being flexible in care delivery protocols.^{43,45,47} In doing so, nurses centered care delivery around women’s cultural preferences. This supports previous research findings articulating cultural competence as necessary to mitigating cultural discrimination that occurs unknowingly.⁵³⁻⁵⁵ Researchers have attributed culturally safe healthcare provision to equitable service delivery and better health outcomes.⁵⁶ Although study participants within this review did not address how cultural safety was promoted

broadly within organizational protocols and policies, most recognized the need to integrate cultural awareness within direct patient care provision.

In addition to being flexible and open to different ways of conceptualizing health and health practices, nurses also described experientially learning about the impacts of migrant status and exposure to trauma and violence on women. Integrating trauma-informed care within delivery of service to immigrant and refugee women was voiced by nurses as challenging due to lack of organizational guidance.^{10,32,46} Although the impacts of trauma on women's health have been well-documented,⁵⁷⁻⁶¹ current literature suggests nurses are limited in their understandings of trauma-informed care practices.^{61,62} While the findings of this review highlighted nurses voicing lack of professional practice support related to understanding trauma-informed care among women with precarious migrant status, studies in this review also highlighted nurse's drawing on their tacit and experiential knowledge to ensure compassionate care provision.

Through providing care to women with multiple complexities, nurses engaged with health determinants that affected the well-being of maternal immigrant and refugee women and their infants. Social isolation, impacts of exposure to trauma and violence and diminished access to prenatal care due to limited health insurance and/or pre-migration contexts of conflict where access to health services were limited were identified by nurses within the studies of this review as shaping how they provided care. As supported by previous research, nurses have the capacity to understand and address disparate health issues faced by women living with multiple layers of adversity.^{63,64} Despite having minimal training on understanding migrant status, nurses within this review demonstrated the ability to identify issues of inequity and poor health outcomes due to the effects of migrant policy on health insurance and ineligibility of social support services.^{10,13,40,41,43,49}

One objective of this review was to capture diverse terminologies used to describe ‘immigrant’ and ‘refugee’ within the 23 studies. In light of this review’s findings where nurses received minimal training on understanding migrant status, the diverse terminology identified within this review can inform and enhance understanding of global migrant discourse.¹⁷ However, understanding the meaning of each term within the context of a country’s migrant and health policies is essential to understanding health implications.

In addition to capturing diverse language used to identify the migrant status of immigrant and refugee women, the multiple terms used to identify nurse participants within studies included in this review were extracted. Eighteen varying terms were used to identify nurses within the 23 studies of this review. These terms reflect the diverse roles nurses work within while caring for maternal immigrant and refugee women. While many terms centered around maternal-child positions, it is significant to note the presence of roles such as psychiatric nursing and chronic disease nursing. This finding suggests that maternal women with precarious migrant status can require care from nurses working in roles beyond the scope of maternal care. As a result, nurses working across healthcare system sectors need to have awareness of health impacts on women with precarious migrant status and integrate this knowledge into care provision tools. This aligns with O’Mahony and Clark’s¹⁵ findings that nurses need more training to care for the mental health needs among maternal immigrant and refugee women. This finding also extends the ICN recommendation¹¹ of nurses being central to refugee and migrant care within crisis contexts to include the multi-sectoral healthcare system contexts around the world. More focus is thus needed beyond the crisis context to provide informed nursing care for maternal immigrant and refugee women within transition and settlement care provision situations. Additionally, the ICN position statement³¹ pays minimal attention to the presence of exposure to trauma and violence among immigrant and

refugee women. As a result, integration of trauma- informed competencies within international and local nursing associations is elemental to enhancing nursing practice and education.

Limitations

This review included studies that were limited in at least three ways: how the nursing voice was captured, how the construct of race was considered, and the geographical study distribution. First, in analyzing how researchers used the term ‘nurse’ within their studies, it was identified by the reviewer that dilution of the nursing voice occurred often where researchers grouped nurses as healthcare professionals, healthcare providers, maternity care professionals or service providers.^{10,32,33,36,43,47,49,50} The unique approach and knowledge nurses employ within provision of care was thus embedded within multiple disciplines and thereby rendered invisible. Effects of this limitation included reducing nurses’ perspectives and diminishing the contributions of nursing knowledge to healthcare sciences. Consequential to the privileging of dominant biomedical ideas and beliefs is the overlooking of the distinct, action-oriented effects of nursing knowledge on the health of complex populations.

Another limitation within studies identified in this review is the lack of capturing race and gender as a health determinant. Current literature describes impacts of race, including discrimination, as fuelling negative effects on immigrant and refugee health.^{31,65} However, few studies within this review explicitly recognized how race and gender were considered within care provision. Study participants were described primarily by their sex only, creating a unilateral depiction of nurses. Although some studies considered migration histories of nurse participants, few considered race, gender, ethnicity or language skills. Unilateral foci perpetuate superficial understandings⁶⁶ of how race, gender, ethnicity, and culture work

together to shape care provision. Such superficiality risks misinterpretation of results and consequential suppression of vulnerabilities experienced by populations such as immigrant and refugee women.⁶⁶ As a result, terms such as race and gender are undergoing critical re-shaping to prevent unintended disregard of disproportionately experienced health issues. For example, international nursing guidance includes paying attention to *how* race is integrated into care provision and *how* discrimination creates barriers to accessing health among immigrant and refugee populations.³¹

Lastly, geographic distribution of studies within this review centred on high income, Northern European, North American and Australian contexts. This reflects Western and Eurocentric approaches to inquiries within this review. Although one study was conducted within Thailand and one in Bangladesh, this review does not reflect globally diverse approaches to inquiry, to nurse experiences of care provision among maternal immigrant and refugee women or to the varying socioeconomic and political forces that shape a country's migration and health policies.

Methodological limitations of this review pertain to inclusion criteria that determined identification of relevant studies. Including studies published only in the English language may have resulted in overlooking studies as well as decreasing generalizability to cultural contexts that speak English. Additionally, including studies only published in English may have contributed to the lack of geographical variety. Although two studies were conducted outside of Europe, North America and Australia, this review has been shaped by Western and Eurocentric ideas of health, migration and nursing.

Another methodological limitation of this study is the inclusion of nurses caring for maternal immigrant and refugee women who experienced pregnancy, birth, or post-birth.

These criteria excluded nurses caring for involuntary migrant women's health in general such as those who had experienced pregnancy loss, infant loss, or abortion.

Conclusion

The central objective of this review was to identify, appraise and synthesize qualitative evidence inquiring into nurse experiences of caring for maternal immigrant and refugee women. The resulting meta-aggregation of appraised evidence generated two synthesized findings summarizing current knowledge: Engaging with cultural and linguistic diversity, and tackling the health effects of forced migration on maternal women. Capturing diverse terminologies conceptualizing 'nurse' led to realizing the wide range of roles nurses work within when providing care to this group of women. The need for integrating understandings across the healthcare system sectors of how precarious migrant status impacts women's health is essential to provide informed nursing care. Additionally, dilution of the nursing voice was realized within many studies included in this review. Articulating the presence of nurses within multidisciplinary teams as well as their role is essential to capture the unique knowledge nurses provide within care provision. Terminology used to discern the migrant status of 'immigrant', and 'refugee' among women was also an objective of this review. In doing so, this review drew attention to the various ways precarious migrant status is worded and the need to further understand consequential health implications among women.

The synthesized findings in this qualitative review reveal that nurses' experiences of various challenges centered around providing care across cultural and linguistic diversity. Nurses centered their care provision on women's cultural traditions and flexed protocols to create culturally safe approaches. Creative strategies based on experiential learning were voiced by nurses as ways to address language barriers. Nurses also recognized the impact of

precarious migrant status on women's health. Social isolation, effects from exposure to varying forms of trauma and violence and diminished access to care due to limited health insurance as well as cultural and linguistic barriers were health issues nurses encountered within care provision. As a result, nurses drew on clinical, relational and population health knowledge to focus care provision on reducing barriers and facilitating connection to social and health systems.

Nurses described developing insights over time around needing to understand how migrant status shaped barriers women faced and thereby deliver effective and equitable care. These findings align with guiding documents describing nurses' roles as including health promotion focused on addressing disparities through a culturally competent lens.^{30,67} However, nurses voiced broader constraints to fulfilling their roles as including lack of organizational commitment to development of administrative and clinical processes targeting enhancing capacity among nurses.

Thus far, systematic reviews on the experiences of nurses caring for maternal immigrant and refugee women have not been conducted. The findings generated from this review have capacity to inform migration and health policy through the experiences of nurses who have identified health disparities among maternal women. They also have capacity to inform professional practice in providing continuous education opportunities related to understanding health determinants faced by immigrant and refugee women such as precarious migrant status and impacts of exposure to trauma and violence. This review is positioned to inform organizational policy to question how administrative and clinical processes accommodate nurses' care provision needs as well as to question how cultural and language barriers are being addressed in culturally sensitive ways.

Recommendations for practice and policy

The Summary of Findings within this review reported moderate dependability and high credibility levels of the findings included. Confidence levels for the synthesized findings was assessed as moderate using the ConQual scoring approach.²³ The following practice and policy recommendations have been graded according to the JBI Grades of Recommendations⁶⁸ and are based on the findings of this review.

- Migrant status is critical to understand as a health determinant shaping women's health. On-going education regarding how local and national migrant policies impact health among maternal women needs to be provided to nurses working in acute and community contexts. This includes providing nurses with understandings of how to assess migrant status and how their status contributes to barriers among migrant women accessing health services. The on-going nature of this education is to accommodate for policy changes. (Grade A)
- Assessing for exposure to trauma and violence among immigrant and refugee women is essential to understand impacts of migration on health. Nurses need on-going support and education related to integration of trauma-informed care within their practice. Organizational policies need to be informed by the need for administrative support that facilitates nurses providing continuity of care among maternal immigrant and refugee women to promote disclosure of trauma and violence exposure and prevent disengagement from the health care system. (Grade A)
- Language barriers can be overcome through creative solutions such as visual aids and body language. Innovative approaches to working across language barriers with nurses in acute and community health contexts to create plans for communicating with immigrant and refugee women when interpreter services are not available need

to be explored and integrated into practice protocols. Institutional leadership need to be involved in these explorations to inform policy changes addressing providing care to women with limited literacy skills across healthcare contexts. Risks associated with using family members as translators need to be integrated into organizational policies. (Grade A)

- Institutional leadership need to include high-risk women with multiple complexities related to lack of antenatal care due to involuntary migrant status or pre-migration experiences into clinical care pathways. Innovative approaches to providing care also needs to be considered with emphasis on enhancing access to healthcare services among involuntary migrant women. Collaborative care centers need to be considered where nurses work with multiple disciplines to streamline care and facilitate health service access. (Grade A)

Recommendations for research

Based on study characteristics and limitations, the following recommendations focus on areas for further inquiry as well as methodological approaches.

- Further research that employs methodologies addressing structural barriers is needed to understand effects of institutional policies on nursing care provision and on the health outcomes among immigrant and refugee women. Framed by an intersectionality lens, this research recommendation has potential to unearth directives that perpetuate barriers and promote discriminatory practices that impact health outcomes. Critical policy analysis and institutional ethnography are recommended approaches to inquire into broader institutional effects on care provision that impact maternal immigrant and refugee women.

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- Further inquiry is needed to examine nurses' experiences of providing care to immigrant and refugee women within acute care settings. This research recommendation entails exploring facilitators and barriers to care within rural and urban acute care settings including emergency rooms and intensive care units. It also entails exploring nurses' understandings of how precarious migrant status impacts immigrant and refugee women's health. Within research inquiries involving interdisciplinary teams, it is recommended nurse's voices are made distinct and explicit through articulation of their roles and unique knowledge base.

Acknowledgments

Please see author's title page.

Conflicts of interest

The authors declare no conflict of interest.

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Summary of Appended Material

Appendix I: Search Strategy

CINAHL Complete EBSCO host

Search conducted on January 13, 2021

Search	Query	Records retrieved
#1	(MH "Immigrants+") OR emigra* OR immigra* OR transient* OR migrant* OR refugee* OR (MH "Refugees") OR (MH "Transients and Migrants") OR MW "asylum seeking" OR "asylum seek"	10,686
#2	nurs* OR (MH "Maternal Health Services+") OR MW health* services OR (MH "Maternal-Child Nursing+") OR (MH "Nurse Attitudes") OR (MH "Attitude of Health Personnel+") OR MW attitude*	122,027
#3	"expectant mother*" OR (MH "expectant Mothers") OR perinatal OR postnatal OR postpartum OR antenatal OR prenatal OR pregnan* OR infan* or MW mother* or mother*	82,399
#4	(MH "Qualitative Studies+") OR (MH "Phenomenology") OR "qualitative" or experience* or perspective* or phenomenol* or ethnograph* or interview* or attitude* or thematic analysis or "mixed method"	198,083
#5	#1, #2, #3 AND #4	394
Limited to: peer reviewed academic journals and dissertations, full text, published between January, 2000 and January, 2021, English language, research article		

MEDLINE with full text (EBSCO)

Search conducted on January 13, 2021

Search	Query	Records retrieved
#1 - refugee	(MH "Refugees") OR (MH "Emigrants and Immigrants+") OR (MH "Transients and Migrants")	7,894
#2 - nursing	"nurs*" OR (MH "Maternal Health") OR (MH "Maternal-Child Nursing+")	106,501
#3 - maternal	"pregnan*" OR (MH "Mothers") OR "perinatal" OR (MH "Postnatal Care") OR (MH "Postpartum Period+") OR "antenatal" OR "prenatal" OR (MH "Pregnant Women")	105,042
#4 - combined	#1, #2, #3	76
Limited to: peer reviewed academic journals and dissertations, full text, published between January, 2000 and January, 2021, English language, research article		

PsycInfo

Search conducted on January 13, 2021

Search	Query	Records retrieved
#1 - refugee	DE "Refugees" or refugee* or immigran* or migrant* or "asylum seeker*" or foreigner*	28,095
#2 - nursing	nurs* or "healthcare professional*" or "healthcare provider"	132,417
#3 - maternal	"mother*" OR "adolescent mother*" OR "single mother*" OR "unwed mother*" OR "prenatal" OR "antepartum" OR "postpartum" OR "pregnan*"	99,793
#4 - combined	#1, #2, #3	354
Limited to: scholarly peer reviewed journals, English, January 2000 – January 2021 publication limits		

PubMed

Search conducted on January 13, 2021

Search	Query	Records retrieved
#1 - refugee	Refugee Query translation (QT): "refugees"[MeSH Terms] OR "refugees"[All Fields] OR "refugee"[All Fields]	15,189
	<u>Immigrant</u> QT: "emigrants and immigrants"[MeSH Terms] OR ("emigrants"[All Fields] AND "immigrants"[All Fields]) OR "emigrants and immigrants"[All Fields] OR "immigrant"[All Fields]	22,300
	<u>Migrant</u> QT: "transients and migrants"[MeSH Terms] OR ("transients"[All Fields] AND "migrants"[All Fields]) OR "transients and migrants"[All Fields] OR "migrant"[All Fields]	18,768
	<u>Asylum seeker</u> QT: "refugees"[MeSH Terms] OR "refugees"[All Fields] OR ("asylum"[All Fields] AND "seeker"[All Fields]) OR "asylum seeker"[All Fields]	13,644
	<u>Forcibly displaced</u> QT: forcibly[All Fields] AND displaced[All Fields]	131
	Immigrant OR migrant OR asylum seeker OR forcibly displaced	80,713

#2 - nursing	<u>Nurse</u> QT: "nurses"[MeSH Terms] OR "nurses"[All Fields] OR "nurse"[All Fields]	374,849
	<u>Healthcare provider</u> QT: "health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("healthcare"[All Fields] AND "provider"[All Fields]) OR "healthcare provider"[All Fields]	668,571
	Nurse OR healthcare provider	898,690
#3 - maternal	<u>Maternal</u> QT: "mothers"[MeSH Terms] OR "mothers"[All Fields] OR "maternal"[All Fields]	416,467
	<u>Woman</u> QT: "women"[MeSH Terms] OR "women"[All Fields] OR "woman"[All Fields]	1,384,459
	Maternal OR woman	1,709,410
#4 - combined	#1, #2, #3 (((immigrant OR migrant OR asylum seeker OR forcibly displaced)) AND (nurse OR healthcare provider)) AND (maternal OR woman)	808
Limited to: full text, English, January 2000 – January 2021 publication limits		

Web of Science Core Collection including Social Science Citation Index

Search conducted on January 21, 2021

Search	Query	Records retrieved
#1 - refugee	(refugee* or immigrant* or migrant* or asylum seeker*)	97,679
#2 - nursing	(nurs* or healthcare professional* or healthcare provider*)	238,955
#3 - maternal	(mother* or maternal or woman or women or pregnan* or prenatal or postpartum)	1,236,494
#4 - combined	#1, #2, #3	769
Limited to: scholarly peer reviewed journals, article, English, January 2000 – January 2021 publication limits		

Google Scholar

Search conducted January 21, 2021

Search	Query	Records retrieved
#1 – combined key words	nurse experiences caring maternal "immigrant and refugee women"	1,680
Limited to: scholarly peer reviewed journals, English, January 2000 – January 2021 publication limits		

Grey Literature Search

Google

Search conducted January 21, 2021

Search	Query	Records retrieved
#1 – combined key words	Global nursing organization and refugee* or immigrant* or migrant* or asylum seeker* and mother* or maternal or woman or women or pregnan* or prenatal or postpartum	4,150
#2	Combined key words with limiters applied	8
Limited to: January 2000 – January 2021 publication, English, contained position statements, reports and press information related to keywords		

Appendix II: Data extraction instrument

Reviewer	
Title	
Author	
Year	
Journal	
Record Number	
Study Description	
Abstract only published in English?	<input type="checkbox"/> Yes <input type="checkbox"/> N/A
Methodology	
Methods Used	
Phenomena of Interest	
<ul style="list-style-type: none"> • Participants are nurses 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure Comments:
<ul style="list-style-type: none"> • Participants care for immigrants and/or refugee mothers 	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:
Other characteristics identified	
Healthcare setting	
Geographical setting	
Concept Description	

Terminology used to identify:	
<ul style="list-style-type: none"> • Nurses • Immigrants • Refugees 	
Other characteristics identified	
Study Findings	
Key findings	
Implications	
Reviewer Comments	

Appendix III: Studies ineligible following full text review (n=13)

Study	Reason for exclusion
1. Burchill J. Safeguarding vulnerable families: work with refugees and asylum seekers. <i>Community Practitioner</i> . 2011;84(2):23-26.	This study does not include nurses and does not present all findings.
2. Chen C-I, Huang M-C. Exploring the growth trajectory of cultural competence in Taiwanese paediatric nurses. <i>Journal of Clinical Nursing</i> 2018;27(23-24):4331-4339.	Although these nurses indirectly cared for families through their paediatric patients, the care being inquired into is not relative to maternal health.
3. Dos Santos SLS. Undeserving mothers? Shifting rationalities in the maternal healthcare of undocumented Nicaraguan migrants in Costa Rica. <i>Anthropology & Medicine</i> . 2015;22(2):191-201.	Data presented in this paper did not present findings on nurse experiences.
4. Griffiths R, Emrys E, Finney CL, Eagar S, Smith M. Operation safe haven: the needs of nurses caring for refugees. <i>International Journal of Nursing Practice</i> . 2003;9(3):183-190.	Did not inquire into caring for maternal immigrant and refugee women.
5. LaMancuso K, Goldman RE, Nothnagle M. "Can I ask that?": perspectives on perinatal care after resettlement among Karen refugee women, medical providers, and community-based doulas. <i>Journal of Immigrant and Minority Health</i> . 2016;18(2):428-435.	Data presented in this paper drew on experiences of doulas and interpreters; no findings on nurse experiences.
6. McKnight P. Australian study reveals challenges faced by maternal and child health nurses in caring for refugee families. <i>Evidence Based Nursing</i> . 2019;22(3):80.	Wrong design – this is a commentary, not a study.
7. Mengesha ZB, Perz J, Dune T, Ussher J. Talking about sexual and reproductive health through interpreters: The experiences of health care professionals consulting refugee and migrant women. <i>Sexual and Reproductive Healthcare</i> . 2018;16:199-205.	Unilateral focus on sexual and reproductive health; Did not inquire into caring for maternal immigrant and refugee.
8. Mengesha ZB, Perz J, Dune T, Ussher J. Preparedness of health care professionals for delivering sexual and reproductive health care to refugee and migrant women: a mixed methods study. <i>International journal</i>	Unilateral focus on sexual and reproductive health; Did not inquire into caring for maternal immigrant and refugee.

of environmental research and public health. 2018;15(1):174.	
9. Oucho JO, Ama NO. Immigrants' and refugees' unmet reproductive health demands in Botswana: perceptions of public healthcare providers. <i>South African Family Practice</i> . 2009;51(3):237-243.	Unilateral focus on sexual and reproductive health; Did not inquire into caring for maternal immigrant and refugee.
10. Payne A. Sexual assault nurse examiner forensic examinations for immigrant victims: a case study. <i>Journal of Forensic Nursing</i> . 2018;14(2):112-116.	Wrong participant population.
11. Ruiz-Casares M, Rousseau C, Laurin-Lamothe A, Rummens J, Zelkowitz P, Crépeau F, Steinmetz N. Access to health care for undocumented migrant children and pregnant women: the paradox between values and attitudes of health care professionals. <i>Maternal & Child Health Journal</i> . 2013;17(2):292-298.	Wrong study design.
12. Vanthuyne K, Meloni F, Ruiz-Casares M, Rousseau C, Ricard-Guay A. Health workers' perceptions of access to care for children and pregnant women with precarious immigration status: Health as a right or a privilege? <i>Social Science & Medicine</i> . 2013;93:78-85.	Health care provision of maternal women not focused on; unclear if nurses were involved.
13. Yelland J, Riggs E, Szwarc J, Casey S, Duell-Piening P, Chesters D, Wahidi S, Fouladi F, Brown, S. Compromised communication: a qualitative study exploring Afghan families and health professionals' experience of interpreting support in Australian maternity care. <i>BMJ Quality & Safety</i> . 2016;25(4):1-9.	Data presented in this paper drew on experiences of midwives and medical practitioners; no findings on nurse experiences.

Appendix IV: Characteristics of included studies

Study	Country	Methodology	Participants	Phenomena of interest	Characteristics of Involuntary Immigrants	Healthcare Setting	Terms used to identify 'Nurse'	Terms to identify 'Involuntary Immigrant'
Degni et al., 2012 ⁴²	Finland	Qualitative: naturalistic descriptive	25 participants; 7 were nurses and identified as female	To explore physician, nurse & midwife communication when providing maternity care to Somali women	Cultural/ethnic minority; low education; involuntary migration as a new phenomenon within country where study was conducted	Family planning and maternal clinics	Psychiatric nurse, family planning nurse, maternity nurse	Refugee, asylum seeker, immigrant
Drennan & Joseph, 2005 ³²	United Kingdom: Inner London	Qualitative: exploratory	13 participants; all were nurses; half identified as immigrants; gender not described	To describe nurses' experiences addressing the health needs of refugee women within 3 months post-birth	Ethnic/cultural minority; homelessness, poverty; experienced war/persecution within countries of origin; experienced neglect and racism from maternity services within country study was conducted	Community clinics	Health visitors	Refugee, asylum seeker
Gannan et al., 2019 ⁴³	Canada: Toronto, Ontario	Qualitative: interpretive descriptive	14 participants: number of nurses not explicated; some identified as	To explore service provider perspectives on facilitators and barriers faced in providing accessible care	Cultural minority; low literacy	"Workplaces": although unclear, authors alluded to community care settings	Service provider	Perinatal immigrant, landed immigrant, family class, refugee, asylum seeking, newcomer

			women, as being immigrants and as having experience with postpartum depression (PPD)	for immigrant women with PPD; services provided by nurses described as first-contact services				
Jean-Baptiste et al., 2017 ¹³	United States: Florida	Qualitative: exploratory	81 participants; 23 were nurses (race identified among entire participant group only; gender not specified)	To understand the needs of immigrant families accessing the Maternal, Infant, and Early Childhood Home Visiting program	Low English proficiency, low socioeconomic status, living in isolated urban areas (geographic isolation)	Funded program sites delivering the Maternal, Infant, and Early Childhood home visiting program	Home visitor, nurse	Undocumented immigrant, immigrant
Kynoe et al., 2020 ⁴⁸	Norway	Hermeneutic qualitative	8 nurses	Exploration of how immigrant mothers without a common language with healthcare personnel experience their stay in the NICU and how NICU nurses experience caring for immigrant mothers and their infants without a common language	Higher incidence of depressive symptoms and psychological distress when babies are admitted to NICU; ethnic minority; low literacy skills	Hospital NICU ward; quiet room	Nurse, certified nurse specialist	Immigrant

Kurth et al., 2010 ¹⁴	Switzerland: Basel	Mixed methodology	10 participants; 3 were nurses/midwives; all identified as women	To identify health needs of asylum seekers attending a women's clinic, to investigate health care received, to explore perceptions of health care professionals about providing health care to women including perinatal women	Experience of trauma (specifically sexual assault and rape in war-conditions); low literacy; experience of fear related to uncertain future	Women's clinic in Basel University hospital; quiet room in hospital or university	Nursing-Midwifery team	Asylum seeker
Leppala et al., 2019 ⁵⁰	Finland	Qualitative	18 participants; 9 were nurses; all identified as female	To investigate factors maternity care professionals identify as hindrances and facilitators for humanitarian migrants' maternity care processes	Socioeconomic status, migrant status as contributing to health experience	Public maternal health clinic; one participant interviewed at her home on request	Public health nurse, registered nurse, maternity care professional	Asylum seeker, humanitarian migrant, quota refugee, newcomer
Lyberg et al., 2012 ⁴⁵	Norway	Qualitative: descriptive and explorative	6 participants; 1 was a nurse and identified as female	To illuminate midwives' and public health nurses' perceptions of managing and supporting prenatal and postnatal migrant women	Ethnic; lack of education; unemployment; low income; 'inferior' socioeconomic status; traumatic war experiences	Vestfold University	Public health nurse; specially trained in management of prenatal and postnatal care for women	Immigrant; migrant
Lyons et al.,	Ireland: greater	Qualitative:	27	To explore the	Ethnic minority;	3 Public health	Auxillary nurses	New migrant;

2008 ⁴⁰	Dublin region	grounded theory	participants; number of nurses not explicated	experiences of maternity service providers caring for ethnic minority women	ethnic and culturally diverse; racialized; limited literacy	maternity hospitals: antenatal clinic, postnatal and labour wards		seeking asylum
Ng et al., 2011 ³³	Canada: Hamilton, Ontario	Qualitative: exploratory	10 participants; 5 were nurses; all identified as female	To understand difficulties health professionals face when delivering care to prenatal immigrant women	Culturally and linguistically diverse; low socioeconomic status; language barriers; ethnic minority	Local clinics and physician offices	Nurse practitioner; health professional	immigrant
Nithianandan et al., 2016 ⁴⁶	Australia: Southeast Melbourne state of Victoria	Qualitative	37 participants of diverse ethnic back-grounds; 5 were nurses	To investigate barriers and enablers faced by health professionals in providing mental health screening within antenatal care provision to refugee women	Experience of trauma; culturally and linguistically diverse	Women's maternity and refugee health and wellbeing services	Maternal and child health nurses, perinatal mental health nurses, refugee health nurses	Refugee; asylum seeker
Origlia et al., 2019 ⁵¹	Switzerland: German speaking part	Qualitative: exploratory	22 participants; 2 were nurses; all identified as female	To describe allophone migrant women's experiences and healthcare professionals' perspectives of communication barriers faced within maternity care	Allophone (do not speak any official languages of host country)	Unclear	Nurse; healthcare professional	Allophone migrant; refugee; undocumented foreigner; asylum seeker
Peláez et al., 2017 ¹⁰	Canada: Montreal, Quebec	Qualitative: multiple case	63 participants;	To understand healthcare	Sociocultural barriers; Non-	Urban teaching hospitals:	Healthcare professional; nurse;	Non-Western migrant; refugee;

		study	39 nurses (gender and migration history gathered but not differentiated among disciplines)	professionals' attitudes and perspectives towards newly-arrived migrant women from non-Western countries who need maternity care	Western minority; experience of abuse, violence and trauma; language barriers; financial hurdles; experience of discrimination and stigma	maternity unit (antepartum, birthing, and post-partum)	nurse manager	undocumented immigrant
Reynolds & White, 2010 ³⁶	United Kingdom: North of England	Qualitative	11 participants multi-disciplinary; number of nurses not explicated	To consider how health practitioners work with asylum seeking women who are pregnant or new mothers	Pregnant and new mothers; experience of trauma and profound loss; language barrier; separation from family; socially isolated	Initial accommodation center	Nurse, professional	Women asylum seeker
Rifai et al., 2018 ³⁸	Southern Sweden: 3 urban and rural municipalities	Qualitative: inductive design	11 participants; all nurses	To investigate public health nurses' experiences of communicating with Arabic-speaking first-time mothers using interpreters	Diverse ethnicities; foreign born; low income; high unemployment rate; isolated; dependant on husband; weak social support system	Child health centres	Public health nurses; registered nurses with specialist training in public health and child/adolescent health (min. 4 years university)	Immigrant
Riggs et al., 2012 ³⁴	Australia: Victoria, Melbourne	Qualitative	18 participants; 12 were nurses; gender of service provider participants not discussed	To explore experiences of using maternal child health services from perspectives of refugee families and service	Culturally and linguistically diverse; financially responsible for family living overseas	2 different organizations	Maternal and child health nurses; refugee health nurses	Humanitarian migrant; refugee

				providers				
Sarker et al., 2020 ³⁷	Bangladesh; Cox's Bazar	Qualitative	19 Service providers in health posts	To explore maternal newborn child health service delivery challenges and potential solutions within a humanitarian crisis environment	Sufferers of hunger, nutrition, safety, and other medical emergencies; 52% are female of which 23% are aged 18-59 years; in Jan. 2019, 22,000 women and girls were pregnant; 1 out of 5 pregnant women sought delivery care; high maternal death rate between 2017 and 2018 (63%).	Health posts and primary health care centers within humanitarian settlement site (community of refugee camps)	Nurse, health provider, service provider	Forcibly displaced, refugees
Seo, 2017 ⁴¹	Thailand: semi-rural area of Chiang Mai	Qualitative: Ethnography	Number of nurses participating not stated; gender not made explicit	To explore how documentation related to pregnancy and birth become objects of hope for stateless migrant women	Ethnic minority; lack of education; low social support; financial barriers; readiness to learn new knowledge and rules; low literacy	Antenatal clinic; government hospital	Nurses – antenatal, delivery, postpartum and neonatal care; obstetric nurses	Documented migrant worker; undocumented migrant; stateless people; non-citizen others; ethnic group; refugees
Skoog et al., 2017 ³⁹	Southern Sweden: Skåne	Qualitative: inductive	13 participants; all nurses; all identified as women	To elucidate nurses' experiences of identifying signs of PPD in non-Swedish-speaking immigrant mothers	Language barrier	Child health center	Child health services nurse	Asylum seeker; immigrant

Teng et al., 2007 ³⁵	Canada: Toronto, Ontario	Qualitative: explanatory	16 participants; 4 were nurses; all nurses identified as female; some had immigrant backgrounds and histories of PP mood disorders	To explore healthcare worker's experiences of providing care to recently immigrated women suffering from PPD	Culturally and linguistically diverse; isolated; some women entering into country through arrange marriage; lack of spousal support	Agencies providing post-partum care to immigrant women	Public health nurse; registered nurse; practical nurse;	Newcomer women, new immigrant
Willey et al., 2018 ⁴⁴	Australia: Victoria	Qualitative: descriptive	26 participants; all nurses	To explore service provision to refugees from perspectives of maternal and child health nurses	Language barrier; mothers; experiences with limited access to health care, exposure to war, conflict, trauma/torture, disease and limited access to basic needs during migrant journey; experience of racism, and discrimination	6 municipalities	Maternal and child health nurses	Humanitarian entrants; refugees; asylum seeker
Winn et al., 2018 ⁴⁹	Canada: Calgary, Alberta	Qualitative: interpretive description	10 participants; 3 were nurses; all identified as women	To understand the experiences of health care professionals providing care to pregnant refugee women	Ethnic/cultural minority; linguistically diverse; experience of violence; diverse migration experiences; diverse education	Refugee specialized, inter-disciplinary clinic (Mosaic Refugee Health Clinic)	Chronic disease nurse, labor and delivery nurse, health care provider	Pregnant refugee women; Syrian refugee women

					backgrounds			
Yelland et al., 2014 ⁴⁷	Australia: Melbourne	Qualitative	34 participants: multi-disciplinary, number of nurses and their characteristics not made explicit	To explore how health professionals working in maternity identify refugee families in their care and how they respond to settlement	Ethnic/cultural minority; low literacy; financially disadvantaged; experience of trauma	Unclear	Refugee health nurse; maternal and child health nurse; health professional; community-based care provider; early childhood nurse	Humanitarian entrant; refugee

Appendix V: Findings, categories and synthesized findings

Findings (n=64)	Categories (n=2)	Synthesized finding 1
Health challenges: Differing expectations of support (U)	Centering care around culture	<p><i>Engaging with cultural and linguistic diversity</i></p> <p>Nurses acknowledged cultural differences among immigrant and refugee women and engaged with ways to integrate cultural awareness within care provision. Centering care around women's conceptualizations of health was a predominant strategy identified by nurses that enhanced their experiences of delivery culturally sensitive care. This strategy was particularly helpful within nurses' experiences of engaging with mental health care delivery. Acknowledging how immigrant and refugee women rely on family members for health information was also voiced by nurses within their experiences of care provision. Nurses also described women as being linguistically diverse which created communication barriers. Experiences with incorporating interpreters within care delivery were described as beneficial. However, diminished rapport with women was a limitation nurses expressed as hampering care provision. While absence of interpreters was viewed as compromising care, using family or software applications such as web-based translation tools were also seen as ineffective. Nurses discussed alternate ways of overcoming language barriers which included body language and the universal demonstration of caring.</p>
Health challenges: Emotional pain (U)		
Knowledge: Assessing impact of PTSD (U)		
Interpreting the mother's mood using cultural knowledge (U)		
Culturally determined barriers (U)		
Identifying and responding to social health issues: The experience of health professionals – Adapting mental health tools (U)		
Identifying and responding to social health issues: The experience of health professionals – Adapting language (U)		
Nurses/Midwives-Somali Women Relationships(U)		
Health care professionals specialized in refugee health engage in diverse strategies of care: Coordinating the care (U)		
Cultural difference: Death of an infant (U)		
Canadian standards of maternity care: Engaging with prejudice (U)		
“Them and Us”: Race (U)		
“Them and Us”: Different to us (U)		
Expectations of provider type and level of professionalism: Avoiding assumptions (U)		
Cultural uncertainty (U)		
The MCH nurse role when working with families from a refugee background: Negotiating traditional versus Western practices (U)		
Striving – sometimes in vain – when screening for PPD (U)		
Intrapersonal level: Provider attributes – enacting cultural competence (U)		
Cultural challenges: Relational diversity – building trust (U)		
Cultural challenges: Lack of assets for social integration (U)		
Social influences (U)		

Nurses/Midwives-Somali women relationships: Cultural understandings (U)		
Nurses/Midwives' perceptions about Somali women's cultural attitudes to reproductive health care (U)		
Challenges migrant women face concerning health care: Meeting cultural needs (U)		
Complexity of the relationship between health visitors and clients who are refugees: Understanding culture (U)		
Cultural challenges: Promoting the women's health and well-being (U)		
Establishing a transcultural supportive relationship (U)		
Establishing a transcultural supportive relationship: Health promotion approaches (U)		
Access to other referral agencies: Strategies to engage with different culture (U)		
Cultural challenges: Linguistic barriers and inconsistency in the use and quality of the interpretation service (U)	Communicating through language barriers	
Challenges migrant women face concerning healthcare: Appreciating cultural and language difference (U)		
Nurses/Midwives-Somali women relationships: Language barrier (U)		
Health challenges: Diversity in education and knowledge (U)		
Communication difficulties: Lack of proficiency in the English language (U)		
Expectation of language (U)		
Expectation of language: Compromised care (U)		
Communication breakdown (U)		
Having to accept and learn to incorporate interpreters when meeting with Arabic-speaking first-time mothers: Enabling an understanding for the situation of the mothers (U)		
Having to accept and learn to incorporate interpreters when meeting with Arabic-speaking first-time mothers: Contributing to a trustful relationship (U)		
Interpreting issues (U)		

Psychosocial issues for asylum-seeking women and challenges to the health care professionals: Challenges for health care providers – Language and cultural barriers (U)		
Communication difficulties: Lack of proficiency in the English language – Effects on rapport (U)		
Communication difficulties: Use of professional interpreters (U)		
Pregnant refugees are a heterogeneous population facing multiple barriers to care: Language and comprehension (U)		
How to identify women from a refugee background (U)		
Promoting continued engagement with the MCH service: Working with interpreters (U)		
Health care professionals specialized in refugee health engage in diverse strategies of care: Clear communication (U)		
Health care professionals specialized in refugee health engage in diverse strategies of care (U)		
Health visitors' perceptions of successful outcomes of their work (U)		
Communication and caregiving despite lack of a common language: caring as universal (U)		
Bedside communication tools and interpreters – mistranslation through family interpreters (U)		
Bedside communication tools and interpreters – mistranslation through technology (U)		
Expectation of language: Protecting confidentiality (U)		
Communication difficulties: Use of informal interpreters (U)		
Having to accept and learn to incorporate interpreters when meeting with Arabic-speaking first-time mothers: Creating disturbing elements in the dialogue – Ensuring confidentiality (U)		
Having to accept and learn to incorporate interpreters when meeting with Arabic-speaking first-time mothers: Creating disturbing elements in the dialogue (U)		

Decision to seek care: ‘Whoever holds the language’ – Making first contact (U)		
Communication and caregiving despite lack of a common language (U)		
Using different communication strategies (U)		
Using different communication strategies –communicating reassurance as challenging (U)		
Using different communication strategies – not knowing mothers’ backgrounds (U)		
Bedside communication tools and interpreters		
Social isolation: Language barrier (U)		

Findings (n=51)	Categories (n=2)	Synthesized finding 2
Canadian standards of maternity care: Inequities in status (U)	Seeing and acting on the impacts of migration on women’s health	<p><i>Tackling the health effects of forced migration on maternal women</i></p> <p>Caring for immigrant and refugee women included witnessing impacts of migration on health and social integration. This included providing care that addressed disparities promoted by migrant policies. Nurses linked these disparities to women not seeking prenatal care and pushing women into further isolation. Harnessing their clinical, relational and population health knowledge, nurses voiced strategies that facilitated health system and social connections for immigrant and refugee women. The realities of providing such care was extended by nurses voicing issues of limited professional and administrative capacities influenced by organizational constraints.</p>
Canadian standards of maternity care: Questioning equitable care provision (U)		
Intrapersonal level: Provider attributes – Understanding women’s experiences (U)		
Access to care and services utilization (U)		
Mutual obligation to care: Equal care provision (U)		
Pregnant refugees are a heterogeneous population facing multiple barriers to care (U)		
Canadian standards of maternity care (U)		
Identifying and responding to social health issues: The experience of health professionals – Identification of refugee background (U)		
Receiving adequate care: ‘You were lucky if you got into the basic maternal health care there’ – Dealing with migrant movement (U)		
Complexity of the relationship between health visitors and clients who are refugees (U)		
Women’s start-up conditions at the time of needing maternity care (U)		

What is working well and what can be done better: Co-location of services (U)		
Fear of incompetence: training versus experience (U)		
Challenges and potential solutions to MNCH service delivery among FDMNs: Challenges – Security (U)		
Identification and prioritization of health needs (U)		
Health care professionals unfamiliar with refugee health may be overwhelmed: Discerning migrant status (U)		
Receiving adequate care: ‘You were lucky if you got into the basic maternal health care there’ – Feeling overworked (U)	<i>Harnessing nursing knowledge to orchestrate care</i>	
Beliefs and capabilities: Assessing trauma (U)		
Environmental context and resources: Having time (U)		
Funding cuts created a confusing system which jeopardized care (U)		
Intrapersonal level: Provider attributes – adequate time to disclose (U)		
Organizational level: Supports and pressures for service coordination (U)		
Striving – sometimes in vain – when screening for PPD: Feeling frustrated (U)		
Identification and prioritization of health needs: Considering war context (U)		
Impact on health visitors of working with refugee families (U)		
How to identify women from a refugee background: strategy (U)		
Challenges migrant women face concerning health care: Acknowledging trauma and violence (U)		
Health needs: Complexity (U)		
Receiving adequate care: ‘You were lucky if you got into the basic maternal health care there’ – Dealing with chaos (U)		
Health care professionals unfamiliar with refugee health may be overwhelmed (U)		
Access to other referral agencies (U)		

Organizational level: Addressing barriers to accessing care (U)		
Complexity of the relationship between health visitor and clients who are refugees: Dispelling fears (U)		
Complexity of the relationship between health visitor and clients who are refugees: Explaining the system (U)		
Intrapersonal level: Provider attributes – Providing system navigation (U)		
Expectations of provider type and level of professionalism (U)		
Women in transition: Navigating system (U)		
Nurses/Midwives-Somali Women Relationships: Building trust (U)		
Interpersonal level: Relationship approaches – Building trust (U)		
Mistrust of formal systems (U)		
Identifying responding to social health issues: The experience of health professionals – Relationship building (U)		
Promoting continued engagement with the MCH service: Continuity promotes engagement (U)		
Syrian influx created additional strains on existing problems (U)		
Mutual obligation to care: Ensuring correct documentation (U)		
Health care professionals specialized in refugee health engage in diverse strategies of care: Advocating (U)		
Behavioral regulation: Following up (U)		
Mutual obligation to care (U)		
The MCH nurse role when working with families from a refugee background: appointment scheduling (U)		
Challenges and potential solutions to MNCH service delivery among FDMNs: Implementation process – Service delivery (U)		
Challenges and potential solutions to MNCH service delivery among FDMNs: Implementation process – Referral (U)		
Challenges and potential solutions to MNCH service delivery among		

FDMNs: Human Resource – Capacity building (U)		
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Chapter Four: Methodology Manuscript

Kassam, S., Marcellus, L., Clark, N., & O'Mahony, J. (2020). Applying Intersectionality with Constructive Grounded Theory as an Innovative Research Approach for Studying Complex Populations: Demonstrating Congruency. International Journal of Qualitative Methods. <https://doi.org/10.1177/1609406919898921>

Title: Applying Intersectionality with Constructive Grounded Theory as an Innovative Research Approach for Studying Complex Populations: Demonstrating Congruency

What is Already Known?

Constructive grounded theory aligns with central feminist tenets, however, there is a call to clarify which feminist approach is being assumed (Olesen, 2007). Intersectionality has been identified as an emergent critical approach in need of further evolution and refinement (Collins, 2019). Complex populations require innovative research approaches to appreciate the structural forces and multiple intersecting health determinants that shape inequitable health experiences.

What Does This Paper Add?

Our paper advances a research methodology with social justice aims, particularly for those who wish to mitigate health and healthcare inequities faced by complex population groups. With congruency being a benchmark to quality within qualitative research, we demonstrate philosophical and theoretical alignment between CGT and intersectionality. We offer four units of analysis for researchers to build upon when engaging with this novel approach to inquiring into complex populations.

Introduction

It is well-documented that complexity among vulnerable populations is driven by broad structural forces where multiple disparities exist (Pauly, MacKinnon & Varcoe, 2009; Reutter &

Kushner, 2010). For example, populations such as migrant groups, people with substance use challenges, and people with mental health issues are impacted by inequitable health experiences that are shaped by structural determinants such as gender, race and class (Hankivsky, 2011). Although the significance of understanding structural and social determinants shaping health experiences within vulnerable population groups has been validated, such inquiry remains superficial (Browne et al., 2015; Hankivsky et al, 2012). Little attention has been given in qualitative methodologies to how complexities involving multi-level health determinants are addressed. Denzin and Lincoln (2018) support this claim in their recent call for needing innovative ideas to evolve social justice methodologies toward understanding complex populations. Such populations can be understood as those experiencing health disparities that are socially and structurally constructed by determinants influenced by oppressive forces such as health and social policy (Varcoe, Pauly & Laliberté, 2011; World Health Organization, 2009).

In our commitment to enhance research inquiries into complex populations, we wonder how qualitative health researchers can enhance the understanding of multi-layered experiences that are influenced by broader sociopolitical and economic structural forces? To address this question, we propose to innovatively advance constructive grounded theory (CGT) as a methodology with social justice intentions, through applying intersectionality as an emergent critical social theory within qualitative research. In doing so, we also aim for continuous evolution of intersectionality through drawing on qualitative methodology as a conduit for generating knowledge that resists social injustice (Collins, 2019).

Our aim of this paper is to conceptualize the application of CGT with intersectionality and lay foundations for researchers to authentically employ our proposed approach. These foundations are conveyed through demonstrating philosophical and theoretical connectedness.

Such demonstration has been identified by qualitative health researchers as congruency (Whittemore, Chase, & Mandle, 2001). Through our conceptualizations, we pragmatically provide researchers with units of analysis to integrate within their inquiries into complex populations.

Situating Our Qualitative Research Approach

Within the landscape of qualitative methodologies, the intentions of CGT include broadening inquiries focused on understudied, complex human behavior (Charmaz, 2014; Glaser & Strauss, 1967; Schreiber, 2001). Awareness of power relations within the researcher-participant relationship is also central to CGT (Charmaz, 2014). These intentions fit well with our critical feminist situatedness. With multi-layered and multi-level influences driving the complexities faced by vulnerable populations, we realized the need to build upon CGT intentions to appreciate feminist tenets focused on complexity. Intersectionality fit into this theoretical optic.

We draw on Collins's (2019) interpretation of intersectionality as an emerging critical social theory. Collins (2019) explains how intersectionality is situated within the crossroads of critical analysis and social action. Being within this crossroad means employing intersectionality as a social theory while ensuring sustained reflection on its objectives and analytical aims (Collins, 2019). Although intersectionality has already been claimed and discovered by multiple disciplines, many have left philosophical assumptions and historical roots unexamined. As a result, intersectionality has matured and moved forward quickly without much reflection or critical exploration. Now emerging into a critical social theory, researchers engage with intersectionality to describe and challenge social inequities with intention to influence change. The notion of interconnectedness being a pillar of intersectionality (Collins & Bilge, 2016;

Crenshaw, 1991) guides our focus toward the interplay of constructs including race, class and gender as interdependent systems of power. In addition, production of social inequality through intersecting power relations and how these power relations drive health experiences are focal points of Collins's (2019) insights. We also align with Hancock's (2007) and Hankivsky's (2014) uptake of intersectionality which directs our attention toward unanswered questions and unconsidered issues. Our discussion of intersectionality is also situated pragmatically as an analytical tool guiding attention toward structurally embedded influencers and critiquing domineering knowledge (Collins, 1993; Collins & Bilge, 2016; Crenshaw, 1991). Intentions of this uptake include fostering contextualization of power relations and better understanding perpetuating inequities (Clark & Vissandjée, 2019; Collins & Bilge, 2016).

Importantly, we acknowledge intersectionality as situated within Black and Indigenous women's experiences of identity, and the multi-layered, influential forces that shape these identities. Collins (2019) provides examples of these broad forces as ideologies such as neoliberalism, capitalism, racism and imperialism which drive complexity and influence inequities experienced within social life. With more recent development of intersectionality through seminal scholars such as Patricia Hill Collins (1993, 2015, 2019), and Kim Crenshaw (1991), we were collectively inspired by the capacity to shed light upon often ignored forces that shape identities and health experiences. Our resulting integration of intersectionality and CGT became a unique research approach expanding the critical feminist intentions of CGT. In exploring this approach, we are also responding to Olesen's (2018) claim that applying intersectionality within qualitative health research is an emergent critical trend. However, as Whittemore et al. (2001) advise, methodological connectedness with a researcher's theoretical perspective is essential to rigorously ground inquiries. Collins (2019) supports this advice in her

call to refine and evolve intersectionality through critical application with congruent methodologies. Although intersectionality has been explicitly applied to CGT methodology in one study (Lindgren, Annerstedt, & Dohlsten, 2017), little has been done methodologically to critically analyze such connectedness. As a result, we focus this article on establishing congruency between CGT and intersectionality as an emergent critical social theory and an analytical tool (Collins & Bilge, 2016; Hancock, 2019; Hankivsky & Cormier, 2009). We argue the need for this congruency to foster philosophical and theoretical connectedness which form a rigorous pathway for researchers inquiring into complex population groups.

We begin this conceptual paper by describing the evolution of grounded theory (GT) into its current three strands. We then describe the roots of intersectionality and its philosophical underpinnings. To foster theoretical connectedness, we critically explore congruency between intersectionality and Charmaz's CGT. Through our exploration, we propose four units of analysis: reflexivity, complexity, social justice, and variability. We explore conceptualizing these units of analysis and offer pragmatic implications and exemplars for researchers adopting our proposed approach. In outlining exemplars, we showcase how researchers can capture stories of participant experiences using both CGT and intersectionality. Limitations of our approach are reviewed to stimulate questioning issues needing further thought on building on our perspectives.

Grounded Theory

Historical Overview

In 1967, sociologists Barney Glaser and Anselm Strauss merged their diverse academic backgrounds and co-founded GT (Bryant, 2009; Charmaz, 2014). Glaser was influenced by his academic work with Columbia University scholars Paul Lazarsfeld and Robert Merton. As a result, quantitative rigor and development of middle-range theory were central to Glaser's

training and efforts to shaping GT (Charmaz, 2014). Strauss's mentors originated from the Chicago School of Sociology and included George Herbert Mead, John Dewey, and Martin Blumer. Through the teachings of these iconic social scientists, Strauss contributed key philosophical and theoretical foundations of pragmatism and symbolic interactionism to the development of GT (Charmaz, 2014; Stern & Covan, 2001). After meeting in the University of California San Francisco through the School of Nursing, Glaser and Strauss combined these perspectives toward their common goal of developing sociological theory. The intention of GT was to generate theory that described social phenomena through focus on patterns of human behavior (Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1998). Although GT has advanced since its inception into three unique stances, Glaserian, Straussian and Charmaz's CGT, the original intention of exploring complex human interactions remains central (MacDonald, 2001). The notion of complexity enmeshed in human behavior is valued within GT where social interactions are explored over time and varying contexts.

Philosophical Underpinnings

The initial GT work Glaser and Strauss published in the 1960s was underpinned by a realist ontology and objectivist epistemology that combined factor analysis, pragmatism and symbolic interactionism (Aldiabat & Le Navenec, 2011; MacDonald & Schreiber, 2001). This collaborative effort reflects Glaser and Strauss' academic backgrounds and also potentially creates philosophical tension. Can a realist ontology align with constructionist beliefs where multiple truths exist? This conundrum was addressed in the 1990s where scholars started deconstructing GTs foundational underpinnings. For example, Strauss and postdoctoral student, Juliet Corbin, reconceptualized GT towards a relativist ontology and subjectivist epistemology (Annells, 1996; Benoliel, 1996; Cisneros-Puebla, 2004; Mills, Bonner, & Francis, 2006). While

a distinct bifurcation into two strands of GT resulted from Strauss and Corbin's reconceptualization, symbolic interactionism and pragmatism continued on as fundamental to the methodology. These philosophical pillars are also foundational within the third strand, Charmaz's CGT.

Charmaz's Constructivist Grounded Theory

Although Kathy Charmaz was a student of both Glaser and Strauss, her interests leaned on Strauss and Corbin's conceptualizations. In developing the third strand of GT commonly known as Charmaz's CGT, she assumed a relativist ontology with a subjective epistemology emphasizing social construction of knowledge. Distinctly, Charmaz emphasized researchers' influences and contributions to social construction (Mills et al., 2006). The concept of researchers as co-producers of knowledge is central to critical feminist methodologies where awareness of inclusivity and power differential are present throughout the research process (Charmaz, 2014; Clarke & Friese, 2007). Charmaz's CGT guides researchers to reveal, examine and scrutinize their assumptions and decision-making (Charmaz, 2014; Olesen, 2007). Thus, researchers are informed by the feminist concept of reflexivity and mindful of superimposing on the experiences of research participants. As a result, although researchers are co-producers of knowledge, intentions of highlighting the voices of research participants within this knowledge is prioritized. Charmaz (2009, 2012) ensures researchers are self-aware of their role within GT inquiries by encouraging application of theoretical lenses that concentrate on social justice and societal issues. It is well-understood in current health research, that societal issues are fraught with multi-level complexity and inequity (Clark, 2018; O'Mahony & Clark, 2018; Pauly, MacKinnon & Varcoe, 2009). Thus, implications of embracing versatility within Charmaz's CGT include having freedom to explore differing theoretical lenses that appreciate such

complexity. The use of a critical theory that captures complexity through magnifying intersections of social concepts can benefit researchers in generating theory that reveals overlooked health needs (Van Herk, Smith, & Andrew, 2011). One such emergent critical theory that centers on complexity is intersectionality.

Intersectionality

Throughout the research process, researchers are informed by overarching critical feminist tenets. However, Olesen (2007) argues researchers assuming a critical feminist stance need to be clear on how they are approaching GT. In addition, Charmaz (2014) calls for understanding the potential for advancing critical inquiry within grounded theory. The critical feminist landscape includes multiple paradigms that provide unique lenses to approaching methodology. In our aim to address complexity within populations experiencing multi-layered, interlocking forces of inequity, intersectionality became the feminist stance that aligned with our situatedness. As an emerging critical social theory and an analytical tool (Collins, 2019; Collins & Bilge, 2016), we employ intersectionality to specifically and pragmatically address the interplay of multiple social locations among complex populations.

Viewing intersectionality as an analytical tool allows identification of unchallenged knowledge that perpetuates inequity among populations living in the margins (Collins & Bilge, 2016; Hancock, 2019). Our approach also guides the research process. For example, how questions are structured, how a study can be conducted and how results are interpreted are influenced by the premises a researcher assumes (Guba & Lincoln, 1994; Hancock, 2007; Hankivsky & Cormier, 2009). To gain more insight into intersectionality, we turn to the historical roots of feminism where social justice and human rights activism shed light on inequities going unnoticed.

Historical Exploration

The 1960s and 1970s comprised of second wave feminism and activism where the notion of ‘woman’ was voiced unilaterally. This focus on sex and gender created discord as dimensions of race were being overlooked (Collins & Bilge, 1996). This discord gave rise to key tenets of intersectionality including acknowledging voices going unheard and multiplicity of truth.

Although central tenets of intersectionality were initially developed in the form of texts and social activism, uptake within research and praxis was delayed until the 1990s (Collins & Bilge, 2016). Continuous evolution of intersectionality over several decades and beyond is a distinct feature that enables influence of societal thinking to shape its application.

A historical analysis of intersectionality reveals another distinct feature where appreciating voices of ignored populations including black activists, feminist thinkers, Latina, LGBTQ and Indigenous scholars is foundational (Collins & Bilge, 2016; Hankivsky, 2014). Although there are many voices that have contributed to shaping discourse into a formal critical theory, introduction of intersectionality discourse originated in 1989 through Crenshaw (1991) who continues to advocate for disrupting status quo and perpetual neglecting of racialization and sexism (Columbia Law School, 2017; Hankivsky, 2014; Hankivsky et al., 2019).

Philosophical Assumptions

Ontologically, humans are viewed as complex and cannot be reduced (Collins, 1993; Crenshaw, 1991; Walby, 2009). This complexity extends to the human experience where social locations are positioned. However, these social locations cannot be understood in isolation (Collins, 2015; Van Herk et al., 2011). Consequently, truth can be ascertained through understanding how social locations interconnect and thereby shape experience. A constructive epistemology resonates within intersectionality where social locations are viewed as socially

constructed (Collins & Bilge, 2016; Hankivsky, 2014). Therefore, human experiences are unique and influenced by context. Understanding that these contexts are laden with power imbalance is an elemental assumption within intersectionality (Collins, 2019). Notably, intersectionality is predominantly described as what it *does* rather than what it *is* (Cho, Crenshaw & McCall, 2013) which denotes pragmatism as an underlying epistemic. Ethically, intersectionality can be taken up as a worldview that aims at disrupting inequity and revealing processes of power, privilege and disadvantage among complex populations.

Evolutions and Intentions of Intersectionality

The original intent of intersectionality stemmed from analyzing inequities within axes of racism and sexism to shed light on Black and Indigenous women's experiences that were overlooked and oppressed. Collins built on original intentions through describing societal oppressions as influenced by intersecting patterns of social locations (Collins, 1993; Collins & Bilge, 2016; McGibbon & McPherson, 2011). Examples of social locations include "age, culture, (dis)ability, ethnicity, gender, immigrant status, race, sexual orientation, social class, and spirituality," (McGibbon & McPherson, 2011, p. 61). Although these examples have significant philosophical and historical roots, we embrace social locations as constructs shaping identity (Collins & Bilge, 2016).

Keeping close to central philosophical assumptions, Hankivsky and Cormier (2009) moved intentions of intersectionality forward through their conceptualizations of health inequities. The authors drew on original interpretations of feminism including Black feminism, Indigenous feminism, Latin feminism, and postcolonialism (Collins, 1993; Crenshaw, 1991), and consider the interplay of varying social identities with broad structural processes of oppression and context to shape mental health experiences. Collins and Bilge (2016) articulate how such

interplays need to be considered within policy and practice domains. Answering this call include collaborative works addressing how intersectionality has moved beyond a field of study and into an innovative approach to analyzing inequity (Hankivsky & Jordan-Zachery, 2019).

Implications of intersectionality being applied to disrupt inequity among under researched populations can be seen within current literature. For example, within the nursing discipline, Guruge and Khanlou (2004) apply the concept of “intersectionalities of influence” (p. 37) as an approach inquiring into how race, gender, class, education, citizenship and geographical locations interplay to shape health experiences among immigrant and refugee women. From a social work disciplinary standpoint, Vervliet, De Mol, Broekaert, and Derluyn (2014) take up intersectionality as a *perspective* and a *research framework* to value diversity, empowerment and historical oppression of refugee mothers. More recently, Lindgren et al. (2017) attempted using intersectionality as a framework within their CGT exploring social processes influencing young adults using sports clubs. The authors used intersectionality as an idea where multiple intersecting identities and conditions converge to create a whole. Although findings included identifying a core social process within the context of complex social and power dynamics, demonstrating how intersectionality influenced findings was not explicated. These examples demonstrate the utility of intersectionality by researchers of various disciplinary backgrounds and applied on a diverse array of populations that have historically been neglected in research. Although decades of evolution and shifts in societal thinking have shaped intersectionality, there is a need for innovation in applying intersectionality toward addressing persistent social injustices affecting vulnerable populations. Collins (2019) supports this claim stating intersectionality is an ever-evolving body of knowledge that is ready for practitioners to investigate for diverse conceptualizations. Thus, we move forward to explore congruency in our

aim to refine intersectionality as an emergent critical social theory and advance CGT methodology toward a novel social justice methodology.

Critical Exploration of Congruency

Proposing application of intersectionality as an analytical tool on Charmaz's CGT to understand complex populations requires understanding congruency as well as limitations. We draw on Whitemore et al.'s (2001) guiding principles for developing rigorous qualitative research where congruency is identified as a benchmark of quality. The authors describe congruency as philosophical and theoretical connectedness within the methodology and throughout the research process. We explore congruency through four specific units of analysis. Drawing from Long's (2011) social science lens, units of analysis are descriptors for generalizable elements within research endeavors. This terminology fosters appreciating the unobservable domains embedded within our exploration (Long, 2011). The following units of analysis emerged as foundational domains within our search for philosophical and theoretical connectedness: reflexivity, complexity, social justice and variability.

These domains were developed through a process of comparing and contrasting assumptions, methods and intentions within conceptual and research inquiries engaging with Charmaz's CGT and intersectionality. Through this process, theoretical connections emerged as units of analysis. In highlighting scholarship including seminal work and exemplars, we describe how each unit resonates within Charmaz's CGT and intersectionality (see Table 2). Through this visual, we aim to demonstrate congruency and facilitate conceptualizing how intersectionality as an analytical tool can be applied to Charmaz's CGT.

Table 2

Summary of Congruencies Between Charmaz's Constructive Grounded Theory (CGT) and Intersectionality

Unit of Analysis	Charmaz's CGT	Intersectionality
Reflexivity	Described as an insightful capacity to self-reflect and acknowledge preconceptions and assumptions (Charmaz, 2017; Mruck & Mey, 2007). Critical scrutiny of one's language and underlying influential ideologies is urged (Charmaz, 2017).	Researcher's tacit understandings, situatedness and views on issues being explored need to be used within research inquiries (Collins, 2000). Integrating personal experiences and views challenges hegemonic categorization (Collins, 2000; Crenshaw, 1991).
	Memo-writing can capture power relations where knowledge of self and participant intermingle (Lempert, 2007).	Researchers acknowledge power relations at various levels of interaction through reflexivity (Hankivsky, 2014).

Complexity	<p>Exemplar: Dastjerdi, Olson and Ogilvie (2012) employ memoing to reveal and integrate tacit knowledge and experiences regarding access to health care services among Iranian immigrants.</p> <p>Corbin and Strauss's (1990) conditional matrix exemplifies how complex dimensions interact to influence phenomena</p>	<p>Exemplar: Price (2011) explores taking up intersectionality within inquiries into women of color and reproductive health advocacy. To ensure authentic uptake of intersectionality, the author emphasizes deliberation and reflexive questioning of how intersecting social locations are appreciated at each research process stage.</p> <p>Humans are viewed as complex and cannot be reduced (Collins, 1993; Crenshaw, 1991; Walby, 2009)</p>
	<p>Knowledge as being ever-changing is an epistemic assumption within GT that embraces complexity (Aldiabat & Le Navenec, 2011; Benoleil, 1996)</p>	<p>Multiple dimensions of a human and the processes that drive oppression must be considered (Collins, 1993; Crenshaw, 1991; Hankivsky, 2012)</p>
	<p>Goals of CGT include revealing complexities within interactions and experiences (Charmaz, 2014)</p>	<p>Emphasis is on understanding complexities within intermingling social locations (McCall, 2005)</p>

	<p>Exemplar: Davenport (2017) documents complexity of integrating contextual influencers and unique personal experiences to generate a theory grounded in Iraqi refugee resettlement stories.</p>	<p>Exemplar: Ressler, Strachan and Bailey (2017) focus on complexity in their operationalization of intersectionality through teasing out gender differences within narrative experiences of migrant workers.</p>
Variability	<p>Aldiabat and Le Navenac (2011) describe variability of phenomena as essential to capturing change and multiplicity in behavior, experience and thought.</p>	<p>Hankivsky and Cormier (2009), Wendy Hulko (2009), and Van Herk et al., (2011) claim that intersectionality captures how an individual's identity changes over history, place and time.</p>
	<p>Exemplar: Forsberg, Cavllini, Fridh and Lennerling (2016) provided participants with choice in interview location facilitating empowerment and valuing varied choices. The authors used three data collection methods to capture various reflection forms.</p>	<p>Adopting intersectionality allows analysis of systemic influencers while appreciating variability, fluidity and contingency of oppression (Cho, 2013).</p> <p>Exemplar: Brah and Phoenix (2004) encourage interactional analytic focus on varying subjectivities. Understanding how</p>

meaning, identities and subjectivities differ is specifically encouraged.

Social Justice

Charmaz (2009, 2012) encourages assuming differing theoretical lenses to address social justice and societal issues.

Magnifying intersections of social locations can benefit researchers in generating theory that reveals overlooked health needs (Van Herk et al., 2011).

Unearthing inequity is one intention embedded within CGT that stems from social justice roots of Dewey's pragmatism (Charmaz, 2017).

Promoting social justice through intersectionality occurs through critiquing domineering knowledge, amplifying historically oppressed voices and appreciating multiplicity in the identities of these voices (Bunting & Campbell, 1990; Collins, 1993; Collins & Bilge, 2016; Crenshaw, 1991; Harding, 1987; Im, 2013).

Critical feminist roots help researchers draw attention to injustices embedded within broader sociopolitical influences (Marcellus, 2017).

Exemplar: Vervliet et al. (2014) highlight the perspectives of unaccompanied refugee mothers and the oppressions they faced

Exemplars: Tomm-Bonde (2016) exemplifies social justice through privileging the voices of Mozambican women and girls over institutional messaging of aid agencies.

through being situated within intersections including migration policies, gender, age and motherhood.

Lindgren et al.'s (2017) inquiry into young adults uses CGT and intersectionality as a framework which raised issues of social inclusion and power located within governing standards of sports clubs.

Exploring Conceptualization and Potential Implications

Through these four shared units of analysis, we offer a rigorous pathway that guides researchers toward operationalizing CGT and intersectionality to explore complex population groups. To further conceptualize these four units of analysis, we discuss how reflexivity, complexity, variability and social justice reflect within CGT and intersectionality. Throughout our discussion, interconnectedness of the four units of analysis will be apparent. Although we focus our discussion on relating these domains to our proposed approach, we appreciate the significant histories underpinning each unit. With this paper being focused on methodological conceptualization, we pragmatically hone in on how each unit of analysis could potentially reflect within a researcher's uptake of our proposed approach.

Reflexivity

Reflexivity within CGT is described as an insightful capacity to self-reflect and acknowledge preconceptions and assumptions (Charmaz, 2017; Mruck & Mey, 2007). Rooted in symbolic interactionism, Clarke and Friese (2007) and Charmaz (2014) emphasize the epistemology that both participants and researchers co-create meaning to develop a social process theory. It is therefore critical to recognize how researchers are positioned to influence this process through their values and assumptions. In doing so, researchers are driven to realizing power relations within the researcher-participant dyad. Strategies employed within CGT that ensure researchers address preconceptions and assumptions include memo-writing, theoretical sensitivity and the notion of methodological rigor (Charmaz, 2014; Mruck & Mey, 2007). Consequently, reflexivity is pragmatically integrated into the research process to encourage continuous awareness of power relations. Charmaz (2017) deepens emphasis on

reflexivity by urging critical scrutiny of one's language and underlying influential ideologies. Calling this critical reflection 'methodological self-consciousness', Charmaz (2017) explicates the need for constructive grounded theorists to assume reflexive stances throughout the research process. Taking a reflexive stance is a critical approach to revealing embedded power relations and ideologies which stems from critical feminist underpinnings of CGT (Kushner & Morrow, 2003).

Intersectionality shares this underpinning of magnifying power relations within relationships (Cho, et al., 2013; Collins, 2019). In fact, reflexivity seems to stem from the reason why intersectionality is framed as an emergent critical social theory addressing oppression. This innate use of reflexivity is embedded within the era of feminist activism where self-reflection on race and gender as influencing one's identity led to stark realization of persistent inequitable treatment and broader hegemonic forces. A more explicit definition of reflexivity within intersectionality is made through Hankivsky's (2014) work where reflexivity is positioned as a strategy that acknowledges multiple truths and attends to voices unheard. Hankivsky (2014) broadens application of reflexivity through emphasis on attending to structural hegemony and appreciating the need for diverse perspectives within research and policy making. Thus, Hankivsky (2014) exemplifies how reflexivity within intersectionality can be taken up at micro, meso and macro-levels with intention to magnify power and scrutinize tacit knowledge. In critically honing in on one's biases and positionality, reflexivity can be used to unpack embedded interlocking forms of power differentials and social differences that have influence on decision-making (Cosgrove, 2019; Hankivsky & Jordan-Zachery, 2019). As a result, intersectionality assists researchers to identify with power and privileges and explicates views on who benefits from the inquiry being conducted. These views trickle into how knowledge is

disseminated and taken up within education, policy-making, future research projects and healthcare delivery.

With reflexivity as a shared unit of analysis, applying intersectionality to CGT holds promise of honing in on power relations and broader processes embedded within researcher assumptions and ideas. Drawing on the exemplars provided in Table 2, memoing is a method within CGT that captures researcher ideas throughout the research process (Charmaz, 2014). These memos are considered as data to be integrated into analysis. Intersectionality and CGT share the need to continuously critique this data, however intersectionality pushes this critique toward analysis of social locations and broad processes shaping these locations. Examples of questions that can emerge during this critique include: what social locations are present within researcher ideas? How are the researcher's own social locations reflecting within memos? What broader processes are influencing the interactions of the researcher with the data? Such questioning encourages researchers to articulate their own assumptions and privileges that are perpetuating power imbalances and oppressive processes.

Complexity

In exploring this second unit of analysis, MacDonald (2001) highlights the critical perspective GT provides through drawing out the “essence of complex interactional processes,” (p. 121). Moreover, Aldiabat and Le Navenec (2011) articulate these complex processes as including human interaction, “organizational functioning, social movements, cultural phenomena and interactions between nations,” (p. 1075). The authors philosophically identify truth as being located within the complexities of interaction. Charmaz (2014) exemplifies complexity in her actualization of Corbin and Strauss's (1990) conditional matrix. This analytical tool provides a visual interlinking display that appreciates broad, structural influences and facilitates action-

interaction within these linkages (MacDonald, 2001). This interaction negates linear thinking and contributes to the process-orientated foundations of GT. Corbin and Strauss's (1990) conditional matrix allows consideration of power relations that are contextual and embedded within interrelationships between micro and macro social structures (Charmaz, 2014; MacDonald, 2001). Hildenbrand (2007) exemplifies how using the conditional matrix fostered consideration of relating political socioeconomic issues with national policies to understand institutional problems and experiences of collective groups and individuals. The notion of a visual display as an analytical tool to map complexity is present in most GT studies where conceptual relationships linked to a core social phenomenon are made explicit visually.

The valuing of complexity within Charmaz's CGT methodology is also evident within intersectionality where humans are considered as multidimensional beings (Collins, 1993; Crenshaw, 1991; Walby, 2009). Collins (2019) argues that complexity is central to the interactive and interactional process of intersectionality. Analyses of intermingling social locations being lived, understood and influenced by broader forces are examples of such processes. Researchers employing intersectionality can thus engage with complexity as an ever-present and non-static phenomenon.

With the complexities of interaction reflecting as central within both CGT and intersectionality, researchers can focus on how interactions within the CGT process reflect multiple interlocking social locations. For example, interview questions can reflect inquiry into what influences participants in their interactions with a phenomenon. Data generated through interviews can be analyzed for broader structural forces embedded within these influences. Power relations and consequential inequities located within interactions can be prioritized within data collection and analysis.

Variability

In order to understand depth of human behavior, the concept of change and variability needs consideration. The philosophical underpinnings of CGT are deeply rooted by symbolic interactionism where knowledge is considered as ever-changing (Aldiabat & Le Navenec, 2011; Benoiel, 1996). As a result, human behavior is considered variable and dynamic. This understanding extends into the critical feminist roots of CGT where contextual influences are closely explored for diversity (Chenitz & Swanson, 1986; Wuest, 1995). As in Forsberg et al. (2016), the flexible nature of CGT enabled the authors to employ various data collection methods and empower participants in order to embrace diversity and variability in behavior (see Table 2).

Scholars who harness intersectionality share this domain of variability in their worldviews of human identity. Hankivsky and Cormier's (2009) theorizing is notable in arguing how effective intersectionality is in revealing identity shifts over time and context. For example, Clark's (2018) critical ethnography with Karen refugee women was informed by intersectionality and postcolonial theory. Her work revealed the complex intersection of gender, health literacy and education impacts on how gender roles are reinforced across migration contexts between men and women. The author's findings exemplifies migration and gender roles as varying contextual influences determined by both social and power structures including culture, geography, political conditions and economic circumstances.

Appreciating variability within our proposed approach can take many forms. For example, data collection can include questions that appreciate how participants moving from one country to another have changed over time in their roles as mothers. Recruiting mothers from wide ranges of socioeconomic, age, geographical and cultural backgrounds can capture complex

variations and nuanced understandings in experience which can inform critically oriented praxis toward social change. Through collecting such data, researchers are guided by CGT's theoretical sensitivity (Charmaz, 2014; Glaser, 1978) to theorize and question what is happening within the data. Using intersectionality as an analytical tool, researchers can pay attention to structural and contextual forces influencing patient experience within the data. Theoretical sensitivity also provides researchers with seeing and making connections regarding social locations participants are living with and how oppressive processes are influencing these lived realities.

Social Justice

Aside from Charmaz's (2009, 2012) encouragement for grounded theorists to address social justice by assuming differing theoretical lenses, Kushner and Morrow (2003) emphasize potential for attending to oppression through the GT research process. Marcellus (2017), in her study of the recovery processes of women with young children, found that use of a CGT methodology underpinned by critical feminism facilitated drawing attention to injustices embedded within broader sociopolitical influences. As a result, pragmatic systemic recommendations were made. Attending to such systemic injustices has been documented as a sustainable approach to disrupting social inequity (Pauly, MacKinnon, & Varcoe, 2009).

Researchers using intersectionality as an analytical tool can share this intention of disrupting perpetual health inequity. The historical roots are an indication of how inextricably linked social justice is to intersectionality (Collins, 2019). Social justice as an ethical imperative of intersectionality is brought forward by Collins (2019) with intentions of disrupting binary terms within theory and praxis. Moreover, researchers using intersectionality can disturb reductionist views of health experiences (Walby, 2009). This disruption of understanding social locations as linear and simple opens ways of approaching human behavior and identity that are

continually overlooked and viewed unilaterally. For example, Clark and Vissandjée (2019) examine upstream structural and political processes influencing settlement of immigrant and refugee women. Through their analysis, the authors examine the structural and political processes of social exclusion among minority women at the intersection of gender, healthy literacy and education. Recommendations are made that foster social inclusion within policy-making and disrupt perpetuating inequity.

Social justice is a core intention within CGT and intersectionality. Charmaz (2014) emphasizes CGT researchers to avoid importing theoretical frameworks with embedded hegemonic concepts. Staying close to participant words throughout the research process privileges their views and interpretations. In fact, researchers are encouraged to consider race, class and gender as among a variety of social constructions that need to be defined by participants rather than defined by researchers (Charmaz, 2014). Applying intersectionality as an analytical tool further encourages researchers to inquire into how social locations interplay and interact with broader processes such as racism, classism, and/or neoliberalism. As a result, researchers adopting our proposed approach need to ensure gender and race are among social locations clearly acknowledged and explored for what lies within the intersections. How power relations are situated within these intersections and thereby shape experience is also central to applying intersectionality with CGT.

Limitations

With intersectionality being an ever-evolving body of knowledge (Collins, 2019), we are faced with continuous uptake, conceptualizations and evolutions that can further expand our proposed approach. Thus, we are limited by the current state of what is understood about intersectionality. In addition, although we have described congruency between CGT and

intersectionality, our exploration also consists of identifying limitations within our proposed approach. These limitations reflect what could surface within a research inquiry applying an intersectionality as an emergent critical social theory and analytical tool to Charmaz's CGT. Each limitation we discuss in this section reflects the units of analysis explored in this article.

A limitation of qualitative research identified within the literature concerns reflexivity as a method glossed over by researchers (Gentles, Jack, Nicholas & McKibbin, 2014). Although reflexivity has been a part of the qualitative family of research methodologies including CGT, articulating how researchers have embraced this domain can be shallowly addressed.

Additionally, Mruck and Mey (2007) confirm how researchers' worldviews can limit the reflexive process. Thus, neglecting explicit description of a researcher's situatedness and how reflexivity was addressed can further perpetuate muting of participant voices. This limitation needs further understanding when considering applying intersectionality as an emergent critical social theory and analytical tool to Charmaz's constructive GT.

Although social justice goals include revealing power imbalance and appreciating multiplicity of human identities, a limitation of attending to complexity is locating the various intersections involved. Highlighting certain social locations over others creates privileging and oppression. For example, Monture (2007) identified trending prioritization of the race-class-gender trinity thereby oppressing other social locations. This exclusionary consequence is further politicized by Hancock (2007) who points out how political priorities drive privileging certain social locations over others. As a result, although researchers apply an intersectionality lens with focus on social justice and policy change, further subjugation may occur unwittingly by limiting categorical analysis to race, class and gender only. Dhamoon (2011) centers this privileging of social locations such as the race-class-gender trinity around researcher choice.

Disrupting such reified intersectional groupings has been recommended. This aligns with critical feminist tenets of challenging domineering knowledge. Hankivsky (2012) weighs into this limitation of reified knowledge within the growing body of intersectionality research and encourages researchers to acknowledge embedded privileges.

Conclusion

Although critical feminism is threaded throughout the CGT research process, more clarity on a researcher's feminist stance is necessary (Charmaz, 2014; Olesen, 2007). We propose a novel approach to advancing CGT and evolving intersectionality toward refinement thereby enhancing social justice intentions (Collins, 2019). Our proposal brings together CGT with intersectionality as an emergent critical social theory that guides researchers toward the interplay of social locations and broader driving forces affecting complex populations. To foster philosophical and theoretical connectedness, we demonstrated congruence within our paper between CGT and intersectionality through four units of analysis. These shared units provide a rigorous foundation for researchers to build upon, analyze and integrate into inquiries using our proposed approach. We offer this new perspective to researchers inquiring into complex phenomena particularly with vulnerable populations facing inequities shaped by hegemonic structural forces and processes. Although we have demonstrated congruency, we acknowledge the ever-evolving nature of intersectionality and qualitative methodology. Thus, we encourage further conceptual thinking about our proposed approach to continue moving our intentions of social justice inquiry forward. Actualizing our approach to further understand inequities faced by vulnerable populations is also necessary to further tease out how intersectionality contributes to advancing CGT. We urge researchers to continue building on our proposed approach to promote research endeavors with social justice intentions.

Declaration of Conflicting Interests

The Authors declare that there is no conflict of interest.

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Chapter Five: Substantive Area of Research Manuscript

Kassam, S. (under committee review). Creating safe relational space: A constructivist grounded theory of public health nurses working with mothering refugee women while managing broader forces. Qualitative Health Research.

Abstract

Public health nurses (PHNs) promote the health of complex populations within varying community contexts. Mothering refugee women are one such rapidly growing population in Canada that often enter the health system through PHNs. Little is known about processes by which PHNs deliver care. In this application of constructivist grounded theory and intersectionality as an analytical tool, I sought to understand the processes PHNs enact within their work with mothering refugee women. The basic social process that emerged, creating safe relational space, described how twelve PHNs established trusting relationships with mothering refugee women while managing interlocking structural forces. PHNs described entering into relationships through a process of burning with passion which fuelled moving into two interconnecting, strategy-oriented processes of connecting while looking beyond and protecting from re-traumatization. Fostering independence was the final process where PHNs let go of relationships while moving refugee women into the standard mainstream health care system.

(149/150 words)

Introduction

Reducing inequity is a global and national public health priority (Cusack, et al., 2017; World Health Organization [WHO], 2020). The public health nursing discipline is rooted in addressing inequities through working within a social determinants of health framework (Canadian Public Health Association, 2017). The contribution of public health nurses (PHNs) to the health of complex populations dates back to over a century ago. However, little attention has been given to the unique skillset PHNs require to engage with populations facing multiple complexities (MacDonald et al., 2013; Schofield et al., 2011). Understanding broad social conditions that impact health as well as employing strong advocacy skills to enhance the rights of marginalized populations are examples of such skillsets (Falk-Rafael & Betker, 2012; MacDonald et al., 2013; Pauly et al., 2009; Schofield et al., 2011). One such population is women who are mothering and have been forcibly displaced from their home countries.

Forcibly displaced migrants consist of varying categories including refugees, asylum seekers and undocumented migrants. Over the past decade, over 100 million people have been forcibly displaced from their homes world-wide (United Nations High Commissioner of Refugees [UNHCR], 2020a). Over 26 million of these displaced people are refugees living precariously in host countries awaiting resettlement (UNHCR, 2020b). Of these disturbing numbers, half are women and girls (United Nations Population Fund, 2016; UNHCR, 2020c). Defined by the 1951 Refugee Convention (UNHCR, 2020d), refugees are those forced to leave their countries due to issues including war, persecution and/or climate crises. These issues continue to exacerbate yearly shaping the exponential growth of refugees worldwide.

Canada has a history of welcoming migrant populations including over 700,000 refugees in the past 40 years (UNHCR, 2019). Many refugees settle within Eastern provinces including

Ontario and Quebec, with the first most refugee-populated city being Toronto. British Columbia (BC) is a Western Canadian province where the second most refugee-populated city of Vancouver is located. Within this gateway city, diverse communities with low-cost, affordable housing are where refugee families settle. These include Surrey, Burnaby and Coquitlam where over 6000 refugees have resettled between 2015 and 2020 (BC Refugee Hub, 2020; Immigrant Services Society of British Columbia, 2014).

Public health units are situated within communities across Canada to provide health and wellness services. These units consist primarily of PHNs who predominantly focus on implementing various health promotion programs including maternal-child health and providing immunization clinics (Government of British Columbia, 2020). All territories and provinces in Canada have variations of how PHNs function according to their own unique contexts. However, central responsibilities PHNs work within include health promotion, disease prevention, and population health assessment (Canadian Public Health Association, 2017; Public Health Agency of Canada, 2008). One role central to PHN work is providing care and support to families and mothers in the community (Aston, et al., 2015). I focused on this role and aimed this study on describing the processes PHNs use in supporting mothering refugee women. With public health being one of the primary entry points into the Canadian health system (Canadian Nurses Association-Canadian Medical Association, 2017), four urban public health units located within communities where refugees were densely populated served as the backdrop of this study.

Contextualizing Refugee Women and the PHN Role

Most forcibly displaced women entering Canada are of child-bearing age or already mothering (Brown-Bowers, et al., 2015). However, refugees as a specific population are an emerging area of focus addressed within migrant women's health literature that need further

attention (Edward & Hines-Martin, 2015; Simich, et al., 2005). Most women arrive from living in various conditions ranging from urban dwellings to substandard housing and refugee camps (UNHCR, 2018). Although there is an international legal commitment claiming protection of women and their families within their journeys to safety, an appalling 70% suffer gender-based violence within settings of conflict and crisis (United Nations Office for the Coordination of Humanitarian Affairs, 2016). While these women tend to keep silent about their experiences of violence (Kassam, 2019), they sustain their hope for a better life for their families within hosting and settlement countries. The PHN role in Canada focuses on population health issues and addresses the complex experiences faced by mothering women including those forcibly displaced. PHNs have diverse responsibilities and deliver primary health programming such as home visitation targeting first-time mothers who are disadvantaged socially and economically disadvantaged (Campbell et al., 2019; Olds, 2006).

Method

Constructivist Grounded Theory

Ideal for expanding areas where little is known (Schreiber, 2001), constructivist grounded theory (CGT) was used in this study to describe social processes that occur over time through analyzing varying sources of data (Charmaz, 2014, Glaser & Strauss, 1967, Strauss & Corbin, 1998). Specifically, CGT was employed to amplify PHN stories as well as focus on experiences of power balance and imbalance throughout the research process (Charmaz, 2017; Mruck & Mey, 2007; Shalin, 1991). As a result, CGT provided opportunities to illuminate under-researched processes PHNs used within their work with refugee women. Aligning with the critical feminist tenets of CGT, I applied intersectionality as a guide to analyzing sources of inequities and interrelated social locations as raised by participants (Collins, 1993; Kassam et al.,

2020). Social locations are defined within this study as socially constructed characteristics that shape identity (Collins, 1993; Kassam et al., 2020; McGibbon & McPherson, 2011). In this study, intersectionality was applied as an analytical tool to understand the complexities embedded within processes PHNs undertook to support the health of women who were refugees and mothering. Intersectionality promoted surfacing of broad social, political and economic structures that impacted PHNs experiences of care provision (Collins, 2019; Varcoe et al., 2011).

Ethical Considerations

This study was approved by the Fraser Health Research Ethics Board and the University of Victoria Human Research Ethics Board. In March 2020, data collection was temporarily paused by the ethics review board due to the COVID-19 global pandemic. Resumption of data collection occurred in May 2020 with ethics approval to conduct remote one-on-one interviews of retired PHNs only. In July 2020, ethics approval was received to recruit practicing PHNs through snowball sampling and to collect data remotely.

Participants

PHNs practicing within four health units of the Fraser Health Authority where mothering refugee women often resettle were invited to participate in this study. Excluded from recruitment were PHNs who worked outside of the health authority and PHNs without experience working with refugees. Three differing sampling methods were used: initial, snowball, and theoretical (Charmaz, 2014; Glaser & Strauss, 1967). Initial sampling began through sending an invitation to a manager who supervised two of the targeted health units within Fraser Health Authority. The invitation was an information brochure outlining the purpose and inviting interested PHNs to directly contact me. The manager disseminated the invitation to four health units. After being contacted by interested PHNs, two focus groups and three one-on-one interviews were scheduled

based on PHNs' choices. The first focus group had five participants and the second focus group had two participants. Once participants completed their interviews, snowball sampling occurred whereby PHNs shared study information with other potential participants of this study and to contact me if interested. This technique was used to harness social networks of PHNs located within the four health units I was targeting (Haber & Singh, 2013). Two participants were recruited using this method. Theoretical sampling of data sources included global, national and provincial position statements, intradisciplinary guiding documents, provincial regulatory board competencies and social media postings. Twelve PHNs participated in this study. Ten participants were practicing PHNs, one was a public health unit manager and one PHN had retired one month prior to being interviewed. Participants ranged in years of experience from 4 to 25 years. Within these years of experience, all worked directly with refugee mothers in varying roles including home visitor, immunization service provider and lactation consultant. Eleven participants were Caucasian, three of whom chose to speak about their families' migration histories. One participant was a visible minority who described herself as a migrant woman. Although gender was not explicitly asked, most participants spoke about being a woman and being a mother as significant motivational factors in working with women who were marginalized.

Data Collection

Unique to grounded theory methodologies include concurrent data collection, coding and constant comparison (Charmaz, 2014; Glaser & Strauss, 1967). Collecting participant data included conducting one-on-one and focus group interviews at locations of participants choices. All participants chose to be interviewed at the public health unit where they worked. After reviewing the purpose of this study and inviting questions regarding signed consent forms, semi-

structured interviews were conducted and digitally recorded. Interview duration ranged from 45 to 90 minutes. Using a prepared script with an outline of guiding questions and prompts, I explored PHNs work with refugee mothers. Topics explored included PHN roles of what informed or influenced their work, concerns encountered in working with refugee mothers, prevalence of mental health issues, issues of access to services, and understandings of what guided PHN practice with refugee mothers. PHNs continuously raised issues regarding creating relationships with women who had endured pre-migration trauma and violence during initial interviews. This focus led to amending questions to further explore experiences of working with refugee women exposed to trauma and violence. Snacks were provided to all participants during in-person interviews and gift cards were provided as appreciation of PHN's time and participation. Once interviews were completed, participants were invited to contact me with any questions.

Data Analysis

Digital recordings were transcribed and three coding techniques were applied in this study: initial, focused and axial. Initial coding consisted of line-by-line coding immediately after each interview was completed and transcribed (Bryant & Charmaz, 2007; Charmaz, 2014). Constant comparison of data occurred with focus on finding similarities and differences in participant stories (Charmaz, 2014; Glaser & Strauss, 1967). Actions occurring within data collected were focused on within initial coding. In focused coding, I engaged with frequently occurring codes and developed categories through questioning the data (Birks & Mills, 2012; Corbin, 1986). Intersectionality as an analytic tool informed critiquing the data toward formulating categories that appreciated structural and contextual forces (Kassam et al., 2020). For example, one focus during analysis was how PHNs contextualized their own social locations

within their experiences of providing care to maternal refugee women. Additionally, intersectionality as an analytic tool guided focus on how PHNs described various types of power relations. Attention to patterns of frequently raised concepts fostered theoretical plausibility and confirmed accuracy of the categories being constructed (Charmaz, 2017). Axial coding facilitated my process of reassembling data, building relationships between categories and describing how they are connected (Charmaz, 2014; Strauss, 1987). Diagramming was employed to convey these relationships (Clarke, 2003). Through these iterative coding phases and inductive processes of constant comparison analyses, a basic social process (BSP) emerged as a central phenomenon that was pliable yet resilient and remained visible within all constructed categories (Glaser, 1978; Strauss & Corbin, 1990).

Strategies used to attain rigor included memoing which is pragmatically built into CGT processes to encourage continuous awareness of power relations. Memoing fostered reflexivity and awareness of methodological self-consciousness throughout the research process (Charmaz, 2017; Kassam et al., 2020). Acknowledgement of any researcher bias was addressed through employment of a methodological journal which traced decision-making and situated my social locations, values and assumptions (Charmaz, 2017; Strauss, 1987). Continuous scrutiny of language and decision making occurred and was facilitated through participating within the University of Victoria's Grounded Theory Club (GTC). Through discussing my research processes at the GTC, dialogue centering on decision-making choices fostered mitigation of superimposing data.

In keeping with ensuring a rigorous research process, methodological journaling was approached from a feminist standpoint perspective where I situated knowledge within my social locations (Risjord, 2010). These included being a visible minority, identifying as a woman, and

being a mother. It also included being a first-generation Canadian. My knowledge was also situated within my public health nursing career where I focused on complex maternal-child populations.

Findings

The basic social problem affecting PHNs that emerged within data analysis was establishing trusting relationships with mothering refugee women while managing broader structural forces. PHNs engaged with this problem through a basic social process of creating safe relational space. As displayed in Figure 2, a concentric oval surrounds all processes PHNs used to create safe relational space. Concentricity of this oval represents simultaneous interactions of organizational, sociopolitical and economic structures shaping the processes PHNs used in this study to create safe relational space with mothering refugee women. Embraced at the center of the oval are the processes PHNs used to relationally and temporally work with refugee women who are mothering. The temporal nature of this theory is demonstrated by the arrows where PHNs entered into their relationships with mothering refugee women through processes of burning with passion.

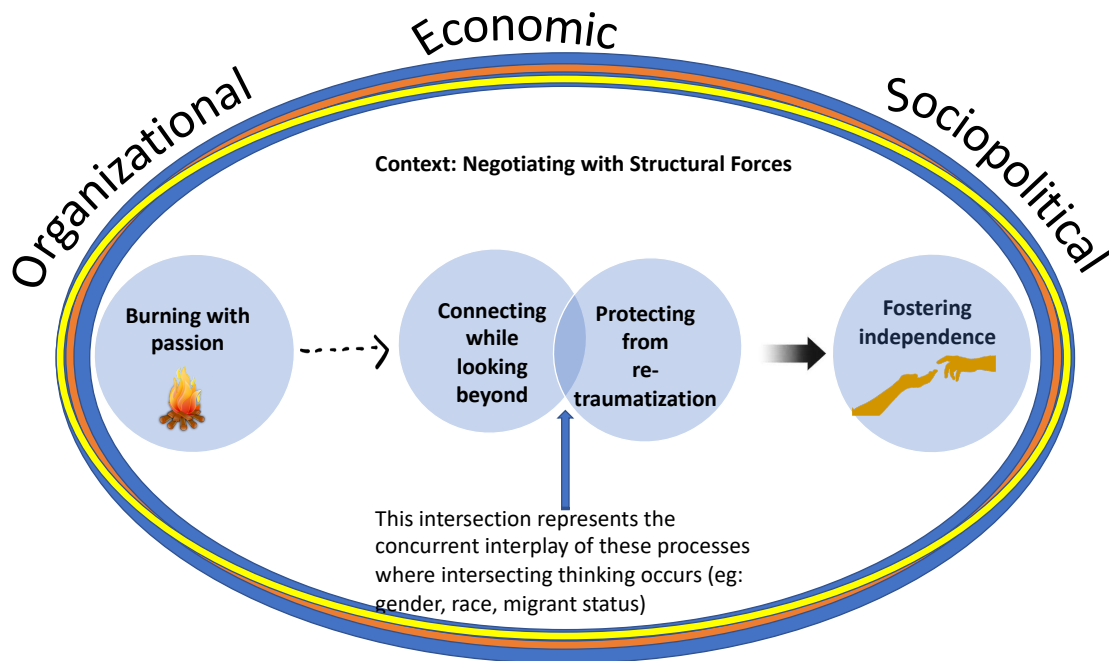


Figure 2: Creating safe relational space: A constructivist grounded theory of public health nurses establishing trusting relationships with mothering refugee women while managing broader forces.

Fueled by this process, PHNs moved into two intersecting processes: connecting while looking beyond and protecting from re-traumatization. PHNs exited from their relationships with mothering refugee women and moved toward a goal of fostering independence. This final process marked the transition of refugee women into mainstream standards of primary health care. All processes occurred within a context of negotiating with structural forces. Drawing on Clarke’s (2003) emphasis on relationships between processes, intersections within Figure 2 are represented by arrows as well as overlapping circles. Displayed distinctly, each arrow was purposely depicted to demonstrate PHNs descriptions of how access to refugee women was gained and how PHNs moved into letting go to foster independence.

Creating safety is drawn from the International Council of Nurses (ICN) code of ethics where *safe* is conceptualized as preserving the dignity and rights of those being cared for (ICN,

2012). Relational space is drawn from Bergum and Dossetor's (2005) relational ethics framework where *space* is defined as the sociopolitical environment influencing care providers and care receivers. This environment consists of structural networks and relationships ranging from personal to global. Personal relationships are how care providers and care receivers relate to one another, whereas global relationships include policy contexts embedded locally, nationally and globally (Bergum & Dossetor, 2005; Cloutier et al., 2015).

Burning with Passion

Participants in this study entered into interactions motivated by their passion for working with complex issues faced by mothering refugee women. Through strategies of reflecting on self and working toward social justice, PHNs self-identified intersections of gender, race, motherhood and migrant status as central within their work with refugee mothers.

Reflecting on Self

Considering their own identities, PHNs articulated intersections of gender, motherhood and professional identity as fuelling their work with mothering refugee women. Describing what invigorated their passion of working with refugee mothers, PHNs turned inward to reflect on their identities. One participant voiced how her own experiences of racial discrimination motivated her work. Similarly, another PHN focused on prejudice and discrimination being experienced by refugee mothers:

My parents immigrated from Holland after the war, and my dad had some stories of when he immigrated and how it was in small town Ontario, which didn't have a lot of immigrants. They spoke reasonable English, they were white Europeans. And yet it was hugely difficult for them. So I can't imagine what it's like when you have

all the prejudice because your skin isn't white. And you have expectations put on you.

While this PHN reflected on her own family migration history, she related challenges faced by her family as being exacerbated within maternal refugee women's experiences due to racialization. Although there was some discussion among participants about racialization, dealing with discrimination was minimally described as a force shaping the context of being a mother and a refugee.

Working Toward Social Justice

Many PHNs in this study spoke about working with mothering refugee women because of their passion for complex populations. Observing refugee women experience multiple barriers fuelled motivation to “help those with more vulnerabilities.” For example, limited literacy was frequently described as a barrier creating a “power difference” when refugee women need to depend on family and spouses for communication. Working within values of social justice, PHNs highlighted power disparities where refugee women were propelled into powerlessness. When asked about the values that guided their work, one PHN described feeling compassion for how refugee women continue to encounter challenges within Canadian health and social systems after enduring turbulent migration journeys:

I mean it just goes along with my compassion for what they've been through and for the understandable difficulties they have, um, with navigating our health care and um adjusting to life in Canada.

This PHN articulated the unique layers of resettlement challenges that further disadvantage maternal refugee women who already face difficulties stemming from forced migration. These included cultural and linguistic assimilation and understanding complex health systems. The

unfairness of this journey was implicitly highlighted. Fuelled by their passion and drive to fulfill social justice values, PHNs entered into their work with refugee mothers and engaged in two interconnected processes: connecting while looking beyond and protecting from re-traumatization.

Connecting while Looking Beyond

This process describes how PHNs established connections with women through considering interconnections of women's migration journeys, culture and gender. Connecting is conceptualized as the process of establishing a relationship. The need to establish a relational connection was inherent across all participant interviews. However, PHNs also went beyond connecting to creatively and flexibly meet the immediate needs of refugee women. Strategies used by PHNs within this process included building trust and engaging with complexity.

Building Trust

Considering the turbulent migration journeys where risk of traumatic and violent experiences are high among women, PHNs described developing trust as essential to connecting with refugee mothers. A focus group of PHNs fervently agreed with one participant who articulated women's migration journeys as influential to trusting and/or mistrusting the new social and health systems:

I always find that trust is a big issue when the families first come, they're not really sure you know, who we're housed with and if they have to worry, because oftentimes where they're fleeing from, you know, they don't have anyone to trust.

Reflecting on the root of trust-mistrust among maternal refugee women, this PHN contextualized building of relationships with the complexities of forced migration. PHNs described ways to

building trust that included: clarifying their role, being friendly and caring, and partnering with organizations refugee mothers trusted.

Engaging with complexity

PHNs described multiple challenges faced by mothering refugee women. Many described these challenges as being embedded within the intersection of social locations. One participant described isolation as a challenge shaped by the gender and culture of many mothering refugee women:

So there are so many intersections in being a refugee woman versus refugee men. Right. And most times, like, with cultural norms, the women don't go outside the homes without their husbands, or they don't have the transportation to go out without their husbands support. Right. So that's, that's another intersection right there. So it is... it's not just like when we talk about refugees. It's not, we cannot make a blanket statement because there are so many layers of the challenges and intricacies that we have to think of.

This participant voiced implications of how gender and culture can shape social integration but also encouraged avoiding generalization of refugee women. Implications of considering intersections of identity included the heightened sensitivity of PHNs to cultural needs. For example, a few participants described a mass immunization clinic venue where they noticed the need to preserve dignity of refugee mothers. PHNs described creatively sheltering these mothers while they undressed and received their vaccinations. PHNs went beyond the mass immunization clinic processes to take time ensuring cultural and gender sensitivity were upheld. Being flexible in accommodating mothering refugee women's needs was a strategy PHNs used to engage with complexity.

Protecting from Re-Traumatization

The experience of forced migration was described by PHNs as intense disruption, trauma and violence. The process of protecting mothering refugee women from further harm was significant among PHNs. This process was strategized through realizing the triggers and walking hand-in-hand.

Realizing the Triggers

With many refugees arriving from war-torn countries, PHNs described wanting to protect mothering refugee women through understanding what triggered emotional upset. This meant revealing triggers that mothering refugee women were aware and/or unaware of. One PHN spoke to dealing with the uncertainty of not knowing these triggers upon engaging with mothering refugee women:

We do go in a bit blind at times in these because we don't always know the situations they have come from or the, like, those stories aren't always shared until something like this happens. And then the story comes out and then we realize the trauma that they have experienced through, and then you can tread a little lighter and be more conscious and cognizant of what they're dealing with and support them.

This PHN promoted shifting practice toward considering and supporting women's experiences of pre-migration trauma and violence and being sensitive to triggers associated with these experiences. It is critical to consider refugee women as having high likelihoods of experiencing pre-migration gender-based violence during their journeys through conflict-ridden countries. One PHN described how the risk for exposure to sexual and physical abuse among refugee women affected her care provision:

My perspective is that, especially again around breastfeeding, there can be a lot of trauma if there's been, you know, abuse of the body, sexual abuse. But I also see it as a way of reclaiming your power and reclaiming your body. And sometimes I have put that forward as an option for [refugee women] to consider.

This PHN focused on the strengths and resilience of mothering refugee women and fostered rebuilding of control and power. Loss of power that comes with experiencing physical and sexual violence was reflected upon by some PHNs. However, PHNs used changes associated with motherhood as empowering refugee women to move toward healing.

Walking Hand-in-Hand

PHNs described this strategy as involving navigating systems and advocating for mothering refugee women. In aiming to protect refugee mothers from further re-traumatization, many PHNs described their commitment to metaphorically walking alongside these women. One PHN discussed steering mothers toward community services as significant to navigation:

But I would say a really big piece as well as the empowerment for these families is not only to you know, walk hand in hand with them through navigating the system, but also, you know, giving them to the community partners and showing them where things are.

In describing her role, this PHN articulated navigation of women toward connecting to sources of community support. In directly connecting women to community partners, this PHN discussed facilitating access to settlement services. Navigating systems was interconnected with PHNs descriptions of advocacy. Described as “helping to be a voice for her when she can’t communicate,” advocacy was highlighted as a broad overarching value driving practice. One

PHN drew on multiple examples outlining ways mothering refugee women's voices were heard and acted upon.

I actually drove [a refugee mother] to the hospital with their baby who had a huge weight loss, was jaundiced, like yellow as ever, and the mum's milk was not coming in and she didn't speak any English. And I drove her to the hospital, walked her into the hospital and said to the nurses there, 'She needs some help, she needs to go to the birthing unit, you need to help her and she needs an interpreter'.

This PHN described knowing the linguistic and cultural barriers this refugee mother faced due to lack of social support and limited understanding of what government health and social services she and her family were eligible for. Knowing these health determinants and barriers informed this PHNs choices to resist organizational constraints to ensure the mother and her baby's health needs were met. PHNs in this study viewed health as multidimensional impacted by broader social structures.

Fostering Independence

Once PHNs moved through processes that fostered creating safe relational space with refugee women, PHNs shifted into fostering independence. This process demonstrated how PHNs moved mothering refugee women toward standard stream integration. Participants equated this standard stream to the societal way of accessing healthcare within Canada. Key strategies of this process included focusing on strengths and bridging to the standard.

Focusing on Strengths

In order to move refugee mothers forward, a strength-based approach was used by PHNs. Participants described strengths as characteristics and social locations situated within the context of forcible migration. Underlining resilience of refugee women and their capacity to care despite

their turbulent migration journeys was central to participant articulation of strengths. Knowledge and resilience were described as stemming from women's senses of faith, culture and desire to ensure safe futures for their children. One PHN honed in on women's capacities to care for their children as significant among refugee mothers:

...it's like they come with a lot of strengths like, like I have, you know, two families that, you know, have beautiful attachment with their children. And even though they've gone through all this trauma and all this kind of stuff, their attachment and their, their caregiving abilities are just like, some of them are just phenomenal, just building on that, that, those strengths are huge.

This PHN voiced informing her practice with knowing refugee women had endured experiences of trauma and violence but also advised emphasizing strengths demonstrated through mothering. Focusing on strengths was a strategy PHNs employed to foster healing and empowerment.

Bridging to the Standard

Participants also described connecting mothering refugee women to standardized practices. Standardization was defined by participants as bringing practices to the same level of similarity as the rest of society. While ensuring refugee women were "accessing like everyone else," and that their health outcomes "come to par with the general population," PHNs identified their role as pivotal to promoting equality and adapting to mainstream health services. One participant described PHNs as "vessels" of knowledge that can facilitate connecting women to resources. Ensuring refugee mothers were connected to the community was described by one PHN as demonstration of bridging refugee women to standardized practices of accessing health services:

So that yeah, hopefully by the end, like say we take them for a year or something like hopefully, by that time, they've been connected with other supports. That by then, they can be accessing care the same as everyone else.

In voicing hope for seamless integration and settlement, this PHN described how refugee mothers needed to become connected to supports within the organizational timeframe directive.

Negotiating with Structural Forces

This process influenced employment of processes and strategies. In this study, negotiating was conceptualized as a leadership competency required to manage ongoing change inherent within healthcare systems. Structural forces were described by participants as broad institutional networks that influenced their practice. Strategies PHNs used in their process of negotiating with structural forces were palpating the changes, and managing system priorities.

Palpating the Changes

This strategy outlines how PHNs keep a pulse on changes within their role as well as within the communities they work within over time. In observing shifts in their role, PHNs described the effect of system changes on mothering refugee women. Many PHNs spoke about how their role within the community had changed over time. These included diminished presence within the community and having little opportunity to connect. One PHN articulated the juxtaposition of a changed community presence and a rapidly changing demographic where large groups of refugees were welcomed into Canada:

...what has really struck me I think because of changes within public health and because of the large influx of new Canadians, our relationship with them is quite different. And in the first 10-15 years of my work, you know, everyone knew who a public health nurse was. And they knew, they expected the phone call when they

came home with a baby and they expected a home visit. And I felt like they knew who I was and I was welcome in the home... And I find with the refugee families, they you know, well generally actually our relationship with the community has deteriorated because we're not visiting like nearly as much as we used to... which is a real source of, you know, of grief for me, but especially within the immigrant communities.

This participant voiced emotion over her waning presence within the community and the consequential diminished relationships with refugee women. PHNs described decreased interactions with mothering refugee women despite increased maternal refugee populations in their communities. Attributing this to fragmented referral pathways to public health units, PHNs described discovering most refugee women by chance “if they present[ed] for immunizations or if a mom [had] a baby”. Another PHN described the way refugee women can access public health nursing “is a broken link at the moment,” where word-of-mouth is the best way to connect with public health unit services. Feeling ill-equipped to understand systems issues, participants focused on “present[ing] the program as it’s outlined”.

Managing System Priorities

PHNs described managing system priorities at point of care to accommodate ongoing health system change. One PHN spoke to broader structural influences of provincial priorities as determining how relationships with refugees developed:

...we used to have a lot more time, and I could follow up a lot more and that time is being squished and squished and squished. So for a while the refugee program, that was the big thing because of that whole the government was supporting it, there was a lot of funding and whatever and as soon as that funding dried up then the

support of the program kind of dwindled and then other things take priority. So having that same relationship that I had in the past with lots of different families... that's been kind of lost over the years.

In describing the change in her PHN role over time, this participant was troubled with organizational reprioritization which defunded refugee-centered programming and reassigned PHNs to institution-led priorities. Flexibility was described by PHNs as central to managing system priorities that did not accommodate mothering refugee women's distinct needs. For example, two PHNs discussed amending home visiting timings to accommodate for refugee mothers needing to connect with family located in their countries of origin:

Yeah, they're often up really late hours talking and talking to people at home. So like early morning visits...they don't do, we don't do. And we are considerate of that...because they're talking to home... that's important for them.

This PHN accommodated women being separated from their family support circles due to forced migration and supported being flexible in carrying out home visitation tasks. In being flexible, PHNs demonstrated moral agency in order to enhance care and mitigate imposing on sociocultural needs of mothering refugee women.

Intersections of Processes

As displayed in the visual diagram (Figure 2), how PHNs establish trusting relationships with mothering refugee women are evidenced by distinct arrows and intersections that demonstrate movement and interaction of processes. Moving into the processes is represented by a broken arrow which symbolized PHN concerns of refugee women being unaware and missing out on public health nursing services. One PHN described mothering refugee women becoming aware only through her social interactions with friends:

I've had many refugee people that were missed in the beginning and they just come to the health unit because one of the friends told them like, Oh, this is where you get immunizations... you wonder how many people are missed in the communities?

This PHN reflected on the implications of current diminished referral pathways and questioned how refugees were being navigated toward public health services.

A faded arrow represented how PHNs moved out of connecting while looking beyond and protecting from re-traumatization toward the final process of fostering independence. The faded arrow signified the role of structural forces in determining when refugee women need to achieve independence. It also signified the hesitance and ambiguity PHNs felt about disconnecting from their connections. One PHN described the emotions of moving refugee mothers toward standardized care:

It's actually really hard. Like, I really dislike it, to be honest. You know, I understand that we can't follow everyone past two years, ... it just feels like an abandonment. It feels unethical... Some people when you leave them, it's time and that's okay. But for some people, it's brutal.

Being left with moral angst, this PHN voiced troubled feelings in needing to disconnect from women who were unprepared for discharge. Although fostering reliance on the health system was an overarching goal, letting go of refugee women was described by many participants as challenging. Many attributed this challenge to broader issues of housing instability and dealing with complex social systems that PHNs were unable to address.

Overlap of processes where PHNs are connecting while looking beyond and protecting from re-traumatization symbolized fluidity where movement between processes occurred

situationally. It also signified strategies within processes as being ongoing rather than episodic. For example, PHNs actively engaged with advocacy to build trust. As one participant advised, “[refugee mothers] need advocacy, they need a friendly face”. PHNs worked within the interplay of the processes they described in this study toward establishing trusting relationships with mothering refugee women.

Discussion

This study builds on current knowledge in at least three ways: how findings contribute to current nursing theory, how findings extend on current understandings of the PHN discipline, and how this study demonstrates the need for intersectionality-framed research. First, this study supports and extends existing research identifying PHNs working within a population health framework (Browne et al., 2010; Cusack et al., 2017; Keller et al., 2011) underpinned by critical caring theory (Falk-Rafael, 2005) to build trusting relationships that fostered addressing unique maternal refugee women’s health needs. Falk-Rafael’s theory proposes caring as a source of knowledge through describing seven health-promoting processes central to public health practice where power is acknowledged between PHNs and their clients (Falk-Rafael, 2005; Hill, 2017). While Falk-Rafael (2005) acknowledges PHN work as shrouded by dominant biomedical paradigms entrenched within health systems, her critical processes highlight relationship-building underpinned by nursing-centric expertise. This study demonstrates how PHNs engaged with this carative process while managing multiple structural forces. The process of managing structural forces aligns with Hill’s (2017) extension of Falk-Rafael’s (2005) ecologically framed critical caring theory that recognizes PHNs navigating organizational complexity in order to preserve disciplinary autonomy. This study builds on Hill’s (2017) extension by highlighting how PHNs go further to also consider the effects of broad sociopolitical and economic structures

on organizational prioritization and decision-making. PHNs in this study described priorities as being driven by public health issues as identified and funded by local, provincial and federal levels of government. The ever-changing nature of these issues were described as guiding government funding decisions and influencing organizational priorities.

This study also echoes Falk-Rafael and Betker's (2012) findings where PHNs work within barriers of limited resources and increased workloads. PHNs in this study supported this scarcity paradigm through expressing recurring issues of lacking time and managing frequent organizational restructuring of priorities. Some studies have identified these barriers as fueled by corporatism (Rodney et al., 2013; Varcoe et al., 2004) and underpinned by limited organizational understanding and value for population health work (Cusack et al., 2017). As a result, public health skillsets have been rendered invisible due to erosion of population-based activities, decades of reform, (Aston et al., 2015; Marcellus & Shahram, 2017; Schofield et al., 2011; Stapleton et al., 2013), lack of public health funding (Pauly et al., 2017), and integration of public health with primary health care (Guyon et al., 2017). This study supports and extends this body of knowledge through demonstrating the effects of an eroded PHN role on maternal refugee women. These include refugee women being unfamiliar with public health services as well as being disconnected from referral pathways leading them to public health services. The resulting impacts of an eroding public health system thus include pushing refugee women further into the margins due to added layers of disadvantage including language and cultural barriers and living in precarious housing and financial conditions.

With participants noting fragmented pathways for these women to connect with public health, and with maternal refugee women facing multiple complex health determinants (Kandasamy et al., 2014; Heslehurst et al., 2018), this study raises questions on how health and

social needs among refugee women are being met. Specifically, with refugee women being at higher risk for experiencing impacts of pre-migration gender-based violence (United Nations Office for the Coordination of Humanitarian Affairs, 2016; Flanagan et al., 2020), this study flags urgent focus on addressing the disconnect of service coordination and how this disconnect is impacting refugee women.

Novel to scholarship aimed at public health nursing work with refugee women is the application of intersectionality as an analytical tool with constructivist grounded theory. Analyses focused on broad structural forces influencing the interplay of social locations and the effects occurring within these intersections (Collins, 2015; Hankivsky, 2014; Kassam et al., 2020). Consequences of this focus included shedding light on the effects of working within a context of structural forces. Applying intersectionality as an analytic tool broadened how PHNs work within a framework that is population-based yet considers social constructs, such as gender, race and migrant status, as determinants shaping health. As a result, findings within this study extend what is currently known about how PHNs understand impacts of health determinants on refugee women (Peláez et al., 2017) to include race, gender and migrant status as significant influences on health experience.

The intersection of race, gender and migrant status brought attention to how a few participants raised racialization as a layer adding to the complexity of mothering refugee women's health. However, it was noted that articulation of racialization as an ideological force impacting health and settlement was minimally described. While cultural safety is a concept that addresses racialization and discrimination (Browne et al., 2009; Curtis et al., 2019), this study raises questions on the structural and praxis integration of how racialization as a health determinant is affecting refugee women. Racine (2014) supports this line of questioning in

arguing for the need to evaluate how cultural safety is employed in nursing practice with specific focus on racialization as a marginalizing force. While initiatives toward cultural safety and cultural competency have been established within nursing (Canadian Nurses Association [CNA], n.d.; CNA, 2021; International Council of Nurses [ICN], 2013), the need to elucidate racialization has been less attended to (Racine & Lu, 2015). This study thus builds on the need to unpack cultural safety from an intersectional lens to highlight how forces of racialization are conceptualized and engaged with within practice.

Research and Policy Implications

Further research is needed to highlight how sociopolitical and economic structures impact public health care provision and the health of complex populations. Systems approaches are critical to understanding the structures disadvantaging populations such as mothering refugee women and can highlight political, legal and ideological forces shaping inequity (Bungay et al., 2009; Farmer, 2004). This study indicates the need for critically analyzing broad, intersecting policies impacting refugee women's health. Such health policies include the Canada Health Act which promises to protect and promote the well-being of those residing in Canada. They also include the Interim Federal Health Program policy directed at overseas and in-Canada coverage. The need to inform policy with refugee women's lived experiences of facing inequities in accessing healthcare services (Floyd & Sakellariou, 2017; Guruge et al., 2018; Winn et al., 2018) is overdue.

Framing research and policy with an intersectionality lens to appreciate complex, interconnected structures is recommended. Employing unilateral approaches includes focusing solely on single social locations such as gender, or race. As challenged by critical feminist thinking, such approaches simplify interlocking structures of race, gender and migrant status and

perpetuate inequities that remain unnoticed and unchallenged (Collins, 2015; Hankivsky, 2014; Collins & Bilge, 2016; Van Herk et al., 2011). Reducing experiences of marginalized populations to singular characteristics include superficial uptake of issues such as trauma and violence (Hankivsky, 2014). While it has been previously recommended that population-based studies have capacity to make visible effects of health inequities on populations with multiple complexities (Pauly et al., 2009), this study adds the effectiveness of intersectionality to this social justice-oriented endeavor.

Limitations

Lack of diversity in participant demographics was a limitation of this study. Although one participant was a visible minority, other PHNs were homogenous in gender, race and migrant status. Despite attempts to recruit PHNs from rural community health centers, participants voicing interest in participating were primarily from urban settings which limited variation and understanding of rural experiences. With this study being a doctoral dissertation, construction of this research was self-driven rather than conducted within a group of authors. However, consistent group discussion did occur through connection to the Grounded Theory Club (GTC) hosted within the University of Victoria, School of Nursing. The GTC was a source of support providing me with opportunities to interact with interdisciplinary qualitative researchers and grounded theorists. Discussion also took place consistently with my doctoral supervisor who is a grounded theorist and provided ongoing methodological support. Limitations resulting from the COVID-19 global pandemic included inability to access PHNs due to temporary health authority suspension of all non-COVID-19 research endeavours. Organizational priorities stymied efforts to recruit PHNs even after suspensions were lifted due

to added epidemiology-focused roles related to varying pandemic responses across health authorities.

Conclusion

This constructivist grounded theory provides understanding of processes PHNs enacted to establish trusting relationships. Creating safe relational space contributes to understanding PHNs unique skillsets engaging with mothering refugee women while managing structural forces. This theory delineates how PHNs negotiate with structural forces while temporally moving through their processes of burning with passion, connecting while looking beyond, protecting from re-traumatization and fostering independence. As a result, this theory provides an articulation of social justice-oriented strategies PHNs used to enhance health through promoting equity and advocacy. Cusack et al. (2017) highlights these competencies as a unique contribution to the nursing discipline. This articulation thus increases visibility of PHN work with a population fraught with complexity.

A novel approach to this study was used through applying intersectionality as an analytical tool with CGT. This resulted in addressing interlocking sociopolitical and economic structural forces that shaped PHN processes. Participant descriptions on how experiences within gender, race, culture and migration are impinged by shifting sociopolitical priorities were highlighted. Impacts of these experiences on refugee women were described as presence of power disparities and inequitable access to public health nursing services. Consequential questions were raised on how the health and social needs among maternal refugee women are being met. Further research is needed on how policies across provincial, national and global levels contribute to these impacts on refugee women. As forced migration continues globally at a rapid pace, the need to inquire into how Canadian policies and practices are supporting the health

and settlement of refugee women in the community. Coordinated efforts to engage with the unique skills PHNs have to offer is a recommended approach to acting on inequities refugee women face.

Acknowledgements

To be written post-acceptance to journal in adherence with blinded peer review process.

Declaration of Conflicting Interests

The Author declares that there is no conflict of interest.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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Chapter Six: The Afterword

The overarching question that frames this afterword is: *How does this dissertation contribute to current literature and to the nursing discipline?* Or in more colloquial terms: So what? In this final section of my publication-based dissertation I synthesize my work through discussing the significance of results generated as well as exploring similarities and differences between the JBI and CGT findings. Implications for nursing will also be discussed related to three core areas of nursing: education, professional practice and research. Implications to policy are integrated within this discussion. Aligning with my pragmatic underpinnings, I will also describe plans for knowledge translation. Or in other words: Now what? This includes a discussion of how I will target dissemination of my findings to audiences including nurses, health leaders, researchers and policy makers. Plans include multi-modal approaches such as conference presentations, journal submissions and web-based activities.

Significance of Findings

To begin, I take a deeper dive into the significance of the JBI findings followed by the findings in my CGT study. Following this discussion of significance, I critically explore similarities and differences between the CGT and JBI findings. Along with being attuned to the similarities and dissimilarities between each inquiry, I was also drawn to what was not being mentioned or challenged. Additional thinking that occurred was questioning what ideologies could be lurking beneath to drive findings that emerged. The predominant ideology that surfaced within my analysis was individualism followed by the goals of efficiency as an effect of corporatism.

JBI Systematic Review of Qualitative Evidence

From the 23 studies included in this systematic review, 115 verbatim findings were pooled into four categories and further aggregated into two synthesized findings: i) Engaging with cultural and linguistic diversity, and ii) Tackling the health effects of forced migration on maternal women. In this section of my afterword, I describe the significance of these synthesized findings through three distinct reflections. The first will describe how nurses in this review resorted to experiential knowledge to inform their practice among mothering women encountering inequities due to precarious migrant status. A second area of significance is how cultural safety and cultural competence seemed to be used interchangeably within the findings of this review and needs further examination. A third area of significance I reflect upon questions why most of the articles within this review came from community settings.

While the JBI findings magnified how nurses in this review enacted healthcare provision with maternal immigrant and refugee women, it was noted that a main epistemological source these nurses drew upon was experiential knowledge. As Estabrooks et al. (2005) discuss in their ethnographic study findings, experiential knowledge in nursing is founded upon an individual's practical experiences as well as the social interactions where experiences are shared and validated. Interestingly, the authors describe the tensions nurses endure when textual knowledge, which commonly reflects organizational change, conflicts with experiential knowledge. The authors claim that nurses valued experience and considered this source of valuable knowledge as evidence over textual sources of learning. As a result, the findings within the JBI study supports the use of integrating experiential knowledge within knowledge translation activities. Kothari et al. (2011) support the use of tacit knowledge as a form of evidence that is often overlooked in favor of traditional research evidence. With nurses within the JBI review experiencing minimal organizational guidance for issues including trauma-informed care and managing limited literacy

when translations supports were absent, exploration is needed on how experiential knowledge can be creatively leveraged within professional practice and policy-making.

However, a critical approach would be necessary to ensure social transformation and healthy equity is fostered. I thereby approach the notion of experiential knowledge with caution. In doing so, I define experiential knowledge through Estabrooks et al.'s (2014) articulations where practice is informed by nurses' observations and experiences of "what has worked or not worked previously," (p. 468). Drawing on intersectionality, experiential knowledge as the sole epistemological platform informing nursing practice holds potential for devaluing complex health experiences. As previously mentioned, an intersectionality-framed perspective is founded upon assumptions where humans are uniquely situated within the axes of diverse social locations. The notion of humans as complex beings thus refutes experiential knowledge as an approach that supports unilateral ways of knowing rather than multiple ways of being. Estabrooks et al. (2014) supports this claim in their warning that the use of experiential knowledge as the sole approach to informing practice is inappropriate and laden with bias.

In this same vein, intersectionality points to the multiple effects of social inequities on populations marginalized by oppressive forces (Kelly, 2011). To fully understand these effects, an open stance of unknowing that seeks the unique stories of those situated within these axes of oppression is necessary. While experiential knowledge could contribute toward the need to remain and enact culturally safe care, the need to be open to presence of gaps in health care systems that contribute to issues of structural racialization and marginalization is critical (Collins, 1993; Collins & Bilge, 2016; Hankivsky & Cormier, 2009). Experiential knowledge thus is an epistemological source that needs to be situated within a position of constant critique.

However, I contend that this position should be structurally supported within institutions employing nurses rather than viewed as the responsibility of nurses alone to interrogate.

Another significant finding within the JBI review involved the integration of cultural awareness, sensitivity and competence within their practice. Nurses in this review relied mostly on experiential knowledge to deliver culturally safe care. This included flexing protocols and centering care around women's cultural traditions. However, with ethnically diverse and indigenous populations facing disproportionate inequities around the world (Anderson et al., 2016; Curtis et al., 2019), the need for rigorous guidance around cultural safety is fundamental. Although the JBI findings described some language around cultural competencies and cultural safety, I question the depth of understanding these concepts and urge further inquiry into how nurses are informed to provide culturally safe care. In doing so, broader understandings of inequitable health experiences faced by populations such as maternal women who have been forcibly displaced can be located within power structures rather than at the individual level. For example, Curtis et al. (2019) explain the importance of knowing how health care inequities are driven by unequal power relations, institutional racism and unexamined privilege rather than not knowing the cultural traditions of a certain country.

If we look at the history of cultural competence which took shape in the 1980s, we can locate working across cultural difference as an individual's responsibility (Curtis et al., 2019; Kumagai & Lypson, 2009). The notion of culture as a competency seems laden with linearity and biomedical tenets where a sense of static rigidity resonates. Indeed, Kumagai and Lypson (2009) critique cultural competence as limited in its intentions and reducing in its goals of achieving quantification of care delivery. The JBI findings thus stimulate thought on how approaches to caring for diverse cultures are integrated into nursing care. With nursing being

situated as a science and art, it would be misaligning and inadequate to frame care provision solely within a cultural competence paradigm without clearly defining the terminology (Browne & Varcoe, 2006; Gerlach, 2012). Moreover, it would miss intentions of locating power structures that perpetuate health inequity (DeSouza, 2008).

While the notion of cultural safety has been proposed by several as a more reflective approach that is amenable to multisectoral integration (Curtis et al., 2019; Truong et al., 2014), critiquing the assumptions within the cultural safety is necessary. For example, what does ‘safety’ mean within the care of maternal women who have been forcibly displaced and endured pre-migration gender-based trauma? Without clearly defining the intentions and philosophical assumptions of cultural safety, the potential to superficially deliver culturally safe care could follow. For example, how cultural safety can be applied contextually to women who have been forcibly displaced would be an area to further examine in order to avoid and perpetuate re-traumatization. Investigating how organizations have embedded cultural safety within their structures would be important to ensure nurses are supported in their work toward health equity.

In reflecting upon a third area within the JBI review findings, I question why most of the review articles came from community settings. A limited representation of nurses working within acute care, specifically emergency room contexts, was noted. However, a debate exists about the use of emergency room departments among immigrant and refugee populations. Several researchers for example, have identified how varying immigrant groups access the emergency department regularly for diverse, non-urgent reasons. These researchers also found that accessing the emergency room was easier where less steps were needed to see a health professional and migration paperwork was not needed to receive care. Specific to migrant women, Credé et al. (2018) found a higher need for obstetrics and gynaecology services during

visits to the emergency room. The researchers suggested that migrant women likely face barriers accessing perinatal and gynaecological services in the community and resort to the ease of receiving health services through the emergency department. However, researchers have also found that refugees and uninsured immigrants, especially women, either avoid or delay seeking care more than those with non-precarious migrant statuses (Gagnon et al., 2013). While some literature is available that looks at the experiences of healthcare professionals providing care to forcibly displaced women in the emergency room, a nursing perspective seems to be missing. Understanding processes of care provision within emergency contexts can help understand nurse interactions with women who have been forcibly displaced and the inequities embedded within these interactions.

Constructivist Grounded Theory Inquiry

Participants within this research described *creating safe relational space* as the basic social process to addressing the core problem of establishing trusting relationships with mothering women who have been forcibly displaced. This basic social process represents a mid-range theory consisting of processes PHNs used within a context of structural forces. These included organizational, sociopolitical and economic structures at the local, provincial, national and global levels. As depicted in Chapter 5, the visual display conveys simultaneous interaction of these structural forces through the concentricity of the oval that embraces the processes PHNs employ.

The first process, burning with passion, brought PHNs into their relationship with mothering refugee women. Expression of passion of their PHN role was expressed throughout data collection and was underpinned by social justice and awareness of the multiple layers of disadvantage these women experienced. PHNs then moved into two intersection processes:

connecting while looking beyond, and protecting from re-traumatization. Movement into these processes was marked by PHNs noting a fragmented pathway within which mothering refugee women came to know about PHN services. Connecting while looking beyond is a set of processes where PHNs worked at building trust through listening, being open, engaging with their culture, and asking questions about their lives pre-migration. Within this work, PHNs simultaneously looked at the broader complexities impacting women's health. These included housing, support systems and migrant status. The second set of processes that PHNs used concurrently was protecting from re-traumatization. Within this process, PHNs were conscious about how the health system could trigger or cause emotional discomfort. Being conscious of potential re-traumatization involved treading lightly with increased sensitivity to triggers. PHNs described walking hand-in-hand to navigate women through systems. Advocating for these women was significant within this process where protecting women from language and cultural barriers was focal. The final process PHNs moved into with mothering refugee women was fostering independence. Moving into this process was challenging for some participants where letting go of women they felt were not ready to continue forward. However, navigating organizational priorities usually took precedence and PHNs engaged with focusing on women's strengths and bridging women to standard practices and resources. These processes were underpinned by the overarching goal of ensuring mothering refugee women accessed standardized health pathways as everyone else did.

Findings generated within this inquiry included the impact of public health nursing as an eroded discipline on the complex population of mothering refugee women. Many participants in this study voiced their dismay with how most women within this population were unaware of the PHN role, the services provided at health units, and the services available in the community.

Fragmentation of referral pathways leading to public health services is a significant long-term consequence of detaching public health nursing from population-focused activities. It is also a barrier to accessing health care provision and a source of inequity faced by mothering refugee women. While we know that the PHN role has changed drastically over time, there seems to be little focus on how populations and the systems they navigate have been affected.

As mentioned by MacDonald et al. (2013), the dwindling political will to evaluate decisions that shift funding away from population health seems to underpin the ignoring of how populations facing multiple complexities are being affected. Could this be reflective of current ideologies that continue to place the responsibility of health on individuals? Individualism and efficiency are pervasive ideologies that are barriers to fostering a health system that prioritizes health equity (Van Roode, et al., 2020). To disrupt such ideologies and pay attention to inequities faced by populations such as mothering refugee women, integration of health equity competencies is suggested by Van Roode et al. (2020).

Findings within this inquiry reflected PHNs having capacity to identify health inequities. However, capacities such as these seem to be stunted by several interlocking issues. One such issue involves the broader political and socioeconomic agendas of prioritizing the acute care, biomedical model of healthcare services. While much of the Western health systems focus on diagnostic interventions, public health nursing centers on operating from a strength-based perspective (Knibbs et al., 2012). This includes promotion of health while building capacity of populations at micro and macro levels (Lind & Smith, 2008; MacDonald et al., 2013). A quick glimpse at history demonstrates the deep-rooted nature of such favouritism toward the biomedical health provision model over the public health models involving social determinants of health. While the health system demonstrates misaligned health provision models and

persistent re-prioritization toward measurable, illness-oriented outcomes, we need to also look at our own nursing discipline. How do our national and international nursing organizations advocate for public health's social justice and health equity oriented value system?

Critical analysis of how public health nursing capacities are recognized and integrated into vision statements and documents is one approach to further understanding stances taken by national nursing organizations. For example, Schoefield et al. (2011) highlight the individualistic scope of the Canadian Nurses Association (CNA) vision that channel PHN work toward individuals and families rather than communities and populations. Additionally, lack of clarity and definition of the PHN role predominates CNA documents suggests the need for building the capacity of public health nursing within national nursing bodies (Schoefield, et al., 2011). This distal approach to reorienting systems toward the social determinants of health framework has been overlooked. Instead, current research has seemingly trended toward understanding how to build the capacity of public health nurses (Kub et al., 2017; World Health Organization, 2017). Attending to the broader gaps of limited intradisciplinary integration of public health nursing may promote shifting the focus from the usual disease-oriented and individualistic mindset toward acknowledgement and application of population health models.

There were many noteworthy findings from this study that I have discussed in Chapter 5. The areas within this theory that struck me included participant descriptions on how mothering refugee women enter into and exit out of public health nursing relationships. PHNs described seeing refugee women facing structural barriers, however the fragmented pathways within which these women navigated to engage with public health nursing services was glaring. While this could be a result of an eroded public health nursing system, it can also be consequential to broader issues of inconsistent provincial and national funding targeting forcibly displaced

populations. For example, the Bridge Clinic located in Vancouver, British Columbia was a health service solely focused on refugee health. Despite Vancouver being among the top three cities in Canada where migrants settle (Statistics Canada, 2016), the Bridge Clinic was terminated due to diminished organizational and provincial funding. The closure was quiet with little evidence of its existence other than the stories provided by health professionals such as the PHNs in my study. The fragmented pathways highlighted by my participants behoves working on how women affected by forced migration are experiencing access routes to health services. Further extrapolation of examining the impacts of fragmented pathways can include populations marginalized by interplaying structural determinants such as gender, race and class. Schaffer, Keller & Reckinger (2015) attempted to examine the impacts of limited to no public health nursing services on community health. Their findings were based on PHN perspectives and included diminished early diagnoses of chronic physical and mental health issues, increased hospitalizations and emergency room visits (Schaffer, Keller & Reckinger, 2015). Lack of public health nursing can thereby lead to an overall decline in the health of populations due to less preventative care and further systemic marginalization of already vulnerable communities.

Participants also focused on how they exited from their relationships with mothering refugee women through their overarching goal of becoming independent consumers of the healthcare system. This push toward independence is worth digging deeper through future research. Questions that arose for me included how do organizations appreciate the communal cultural contexts that most refugees are accustomed to within their mandates that urge prompt discharge of women from public health services? At the clinical level, PHNs were forthcoming in this study and expressed bending administrative processes to accommodate refugee women affected by limited capacities to access health services. Circumvention of system limitations has

been recently attributed to PH practitioners who are highly aware of the ethical issues faced by populations challenged by health inequity (Marcellus et al., in press). Accommodation and circumvention of system processes are among the many PHN activities that go unnoticed, undocumented and thereby unconsidered by organizations, decision-makers and the public (Schaffer, Keller & Reckinger, 2015). This begs the question of how can the PHN voice be considered within organizational policies and directives. The invisibility of PHN work has been well-documented globally (Aston, 2008; Falk-Rafael & Betker, 2012; Meagher-Stewart et al., 2010; Philibin et al., 2010, Schaffer Keller & Reckinger, 2015). However, the pervasiveness of individualism as contributing to this invisibility has been marginally addressed and acted upon.

While the individualistic ideology seems to be lurking beneath much of what the PHN discipline is enduring, we can see the impacts of this ideology trickling down into care provision. Such reflections made me question the following: Does promoting independence among mothering women who have been forcibly displaced empower or further isolate them? Is promoting independence a product of individualism? It is significant to note that while PHNs described working toward ensuring services are accessible, leading women toward independence was fraught with emotion for some. In literature focused on clinical ethics, some have exposed individualism as rooted in Western biomedical values of autonomy which have some protective value, but also have ignored the essence of humans as social beings shaped by connections to others (Dove et al., 2017). In fact, some critics have tied persistent wicked problems within healthcare to individualistic approaches to bioethics and health care provision (Dove et al., 2017; Prainsack, 2017; Priaulx, 2013). In response to PHNs getting caught in their goals of providing culturally safe care to women who come from communal backgrounds, and the organizational goals of promoting independence, PHNs in my study expressed distress when describing their

processes of needing to let go of refugee women who continued facing challenges. Although PHNs voiced feeling deeply troubled by this process, they leaned on their success stories of watching women ‘blossom’ over the duration of their relationship and care provision. This reflects Dove et al.’s (2017) positing of relational autonomy as an ideology that moves away from individualism and promotes interdependence on social surroundings and relationships.

Findings within this study aligned with Falk-Rafael’s (2005) critical care nursing theory which was developed to conceptualize the underpinnings and roots of public health nursing practice. Drawing on Watson’s caring science and critical feminist theories, critical caring nursing provides a midrange theory situates public health nursing philosophically (Falk-Rafael, 2005). Thus critical caring nursing theory provides core competencies, also described as carative processes, centered around relational caring as an ontological pillar. Falk-Rafael emphasizes these carative processes as facilitators employed in public health nursing toward health promotion among individuals, families and communities. In building on this theory, Hill (2017) extended the mid-range theory to include the process of navigating organizational complexity. In this process, PHNs are described as navigating change driven by organizations (Hill, 2017). In doing so, PHNs feel an increased sense of autonomy in generating successful impacts on individuals, communities and systems (Hill, 2017). However, findings within this dissertation study further extend this theory to immerse PHNs into the wider determinants that shape organizational decision-making. These can include historical, socioeconomic, political and global influences that shape organizational complexities (see Figure 3).

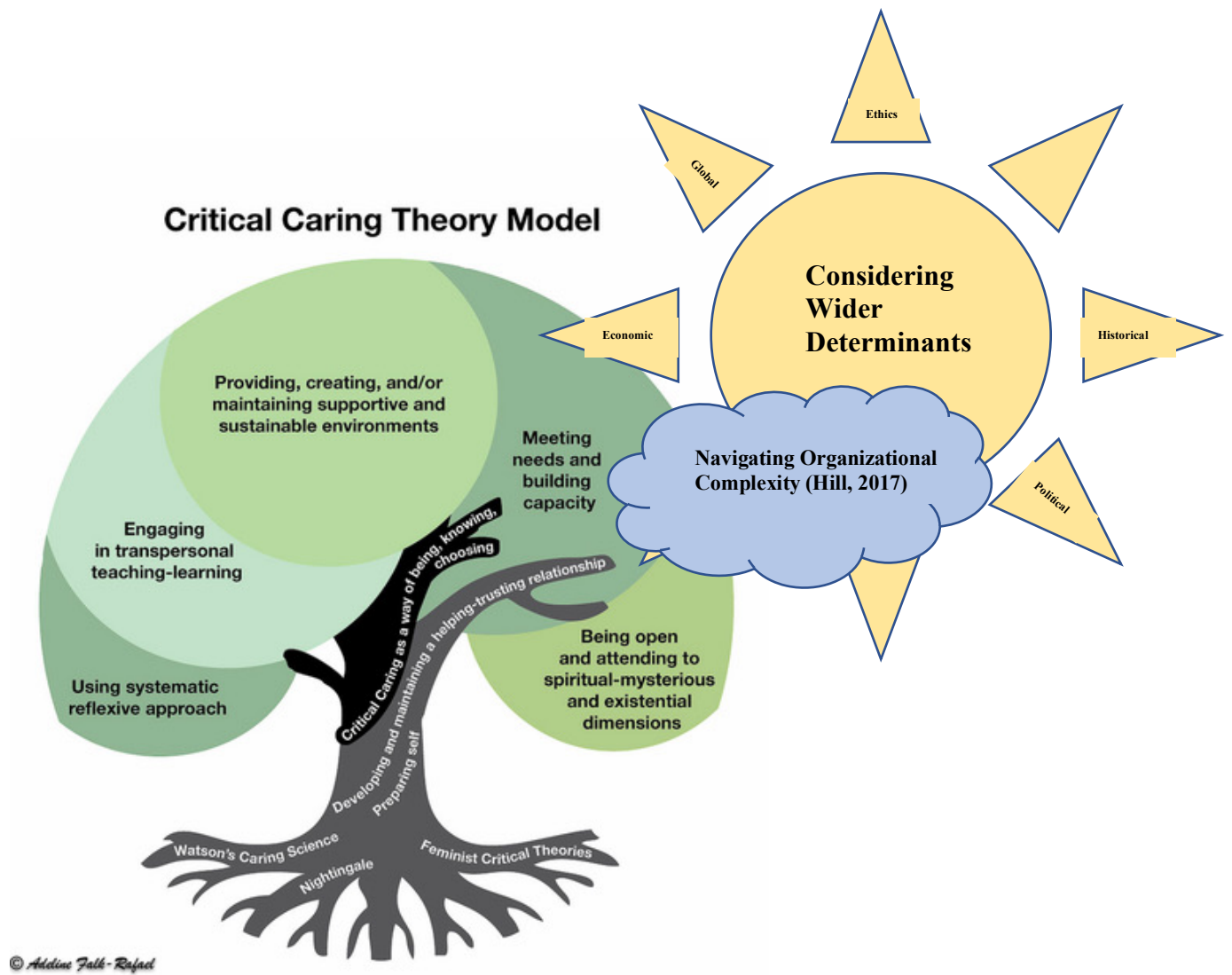


Figure 3: Building on the Critical Caring Theory Model by Falk-Rafael and Betker (Falk-Rafael & Betker, 2012; Hill, 2017; Kassam, n.d.).

While focus on navigating organizational complexity is necessary to appreciate and contextualize the forces PHNs work within, the broader issues that shape organizational systems also need attention. My proposal to extend Falk-Rafael's theory thus brings PHNs into systems-thinking to consider determinants that are shaping their organizational priorities and hence their practice. For example, Guyon et al. (2017) engage with political, economic and historical determinants through questioning why public health has been traditionally pushed aside within health systems across Canada. Their analysis reveals a deeper issue of federal disconnection from public health bodies of expertise. Specifically, Guyon et al. (2017) highlight the Chief Public Health Officer for Canada as historically connected to the role of Deputy Minister of the Public Health Agency of Canada thus undermining and delimiting the advisory potential of public health knowledge. But these challenges are not new, nor are they solely a Canadian issue. Looking at disciplines outside of nursing, Story, Hamm and Wallinga (2009) speak to the 'great disconnect' between food systems and public health leading to misaligned agricultural policies and resulting in exacerbated diet-related disease. From an urban planning perspective, Corburn (2004) attributes the eroded relationship between public health and urban planning to uncoordinated approaches to dismantling health inequities faced by racialized urban populations living in poverty. Global health has also been affected by the divergence of public health from innovation experts and has been linked to set backs within the Sustainable Development Goals (Moran, 2016). While the current pandemic exposes a cracked system both globally and nationally where public health expertise is persistently ignored, one can't help but notice a historical trend. Again, we can link this trend to post-positivist, biomedical frameworks that dominate the Western, high-income countries.

The political disconnection of public health on a federal level has led to local repercussions including direct influence on PHN role erosion (Keller et al., 2011; Schofield et al., 2011). Extending nursing theory to incorporate nurses working within the broader context of political structures has the potential to reignite engaging with distal influences versus merely acknowledging them. In essence, the extension of Falk-Rafael's (2005) theory fuels questioning how engaging with nursing theory can be linked with the politics of caring. Specifically, how has public health nursing care provision been influenced by the Canadian politics and ever-changing agendas? Situating public health nursing within the political framework requires clearly defining the PHN role within a multisectoral collaboration. Jack (2010) articulates this collaboration as bridging the biological and individual determinants with the broader social, economic and political determinants with the intention of influencing the health of populations. This multisectoral positioning of public health nursing is further articulated by Cohen and Marshall (2016) who locate public health institutions as dependent on government bodies. This is problematic and creates a significant barrier where the social determinant of health agenda is frequently overridden by the agendas of the political party in power.

Public health care provision in general faces numerous barriers at the political level. In fact, the 'a-ha' moment that was striking within my CGT inquiry was the moment PHNs realized they were speaking to their own experiences of barriers within their care provision work. This insight made by a PHN shifted the lively focus group discussion toward self-reflection and realization of broader constraints they needed to navigate. Similarly, Cohen and McKay (2010) found PHNs revealing experiences of encountering multiple barriers during their responses to questions on how structures such as public health agencies can address issues of poverty among families in Canada. These included gradual redefinition of the PHN role to exclude health

promotion activities. For example, PHNs in Cohen and McKay's (2010) study voiced a shift in practice toward responding to illness (eg: doing infant bilirubin checks) rather than illness prevention and health promotion activities. So while theoretically PHNs have capacity to step into more community development and health equity-oriented roles, there is much work to be done organizationally and even more broadly at provincial and federal levels and at national nursing organizational levels to recognize the full potential of the PHN role.

Critical Exploration of Findings: JBI and CGT

A unique aspect of my dissertation was combining two distinct approaches to situating mothering women who have been forcibly displaced within nursing. I approach this portion of the afterword by critically examining the similarities and differences between the JBI and CGT findings. This examination includes further situating findings into current literature. Three key areas are explored: migration as a health determinant, working with women who have experienced trauma and violence within their migration journeys, and examining the roots of accessing care.

Viewing Migration as a Health Determinant. A key difference between the JBI and CGT approaches to my dissertation was how migration was conceptualized. Entering into my substantive research, I was focused on honing in on women with refugee status and situating this category within nursing. As discussed in Chapter 1, this focus stemmed from the small yet emerging body of knowledge within nursing that focuses on this population (Almond & Lathlean, 2011; Drennan & Joseph, 2005; Floyd & Sakellariou, 2017; Guruge and Khanlou, 2004; Merry et al., 2011; Racine & Lu, 2015; Willey et al., 2018) and my desire to tease out the refugee experience from a cloudy history of conflated migrant discourse. However, I found myself being driven by this small body of knowledge toward widening my scope within the JBI

systematic review to include women categorized as involuntary migrants who were forced into leaving their country. In doing so, I was able to capture a large body of qualitative evidence as well as include women with varying forced migration statuses including asylum seekers and undocumented migrants. With the processes of JBI methods including peer-review of a protocol prior to beginning the systematic review, I was exposed to international reviewers who introduced me to the term ‘involuntary migrant’ as the globally accepted language used within forcibly displaced migrant discourse. The terms *forcibly displaced migrant status* was thereby used interchangeably with *precarious migrant status* in my attempt to tease out historically conflated migrant categories. Contextualizing migrant status with issues faced by women forcibly displaced was another strategy I used to avoid conflation of terms.

Findings that were reflected within both JBI and CGT inquiries included describing forcibly displaced migrant status as a source of inequity among women. Many nurses within the literature reviewed within JBI spoke to inequities women faced stemming from the precarity of their migrant status. While nurses within the CGT study spoke to Canadian migrant categories of Government Assisted Refugees and Privately Sponsored Refugees as inhibiting access to services, the discourse used by nurses within the JBI study included asylum seeking and stateless women. However, missing from both studies included explicitly speaking to migrant status as a social and health determinant.

Migration in general has been documented as a health determinant by the World Health Organization. More recently, several scholars coming from public health and anthropology backgrounds have shed light on the lack of dialogue between two very interconnected bodies of knowledge: social determinants of health and immigration (Castañeda et al., 2015). Here, the authors convey urgency in filling knowledge gaps related to unexamined institutional practices

and policies that contribute to reduced human rights among immigrant groups. How such forms of exclusion impact varying immigrant populations remains unexplored and limited by simplistic explanations of access to care (Castañeda et al., 2015). These include reduced understandings of gender, ethnicity and race that are decontextualized and separated from historical and political ties (Castañeda et al., 2015). Oxman-Martinez et al. (2005) move beyond the access to care narrative to locate factors contributing to health disparities. These include the complex networks of health and immigration systems as well as the social exclusion of women influenced by social locations including socio-economic status, ethnicity, language and gender. While these authors move beyond point of care perspectives and address inequities embedded within intersections of policy, they also attempt to locate experiences of inequity within the axes of variables such as gender, class, race and ethnicity. More recently, some attempts at further teasing out the determinants of refugee health have been made. Hynie (2018) presents findings from a psychology perspective targeting the impacts of post-migration conditions on forcibly displaced groups and their experiences of mental health issues including post-traumatic disorder. Although this author's findings minimally address the mental health impacts among women of forcibly displaced migrant statuses, Hynie (2018) does attempt to highlight the added layers of disadvantage faced within this particular migrant group. In doing so, she raises awareness of grouping immigrants together with forcibly displaced populations which overlooks the context of involuntary migration. Unwittingly glossing over the context of involuntary migration can also be seen within nursing where integration of migrant discourse into regulatory bodies such as the ICN and CNA includes descriptions of migrant status as an individual circumstance rather than a global situation that has pushed individuals into displacement.

Engaging with Trauma and Violence. Another similarity between the JBI and CGT findings is the discomfort and lack of knowledge nurses expressed in dealing with trauma and violence among women forcibly displaced. While many nurses spoke to strategies used to ensure culturally safe practice, trauma-informed practice seemed less understood. Nurses within both inquiries instead focused on how to relationally connect with women and establish trusting and respectful relationships. Browne et al. (2010) support this approach within their findings where nurses drawing on relational practice have capacity to simultaneously identify, contextualize and act on complex risks faced by populations. However, the issue of unintegrated trauma-informed care cannot be ignored.

As I later discuss within my implications section, several multisectoral initiatives exist that target uptake of trauma-informed care principles. Existence, however, needs to be further contextualized by accountability. Who is accountable for ensuring trauma-informed care is universally part of care provision? Stokes et al. (2017) addresses this question in their findings where nurses were deeply troubled in their trauma-informed practice. The authors found these troubles as stemming from competing demands of a scarcely resourced health care system causing exhaustion, helplessness and frustration. Other studies have identified similar experiences among health professionals addressing complex issues (McElvaney & Tatlow-Golden, 2016; Wolf et al., 2014). While nurses work within environments barraged by checklists and time-sensitive tasks, they also seem accountable for the integration of principles such as trauma-informed care into their practice. This can be viewed as a structural violation and a product of an individualistic ideology that pushes accountability away from organizations. Stokes et al. (2017) state that although trauma-informed care principles align with nursing through central tenets including provision of flexible and relational care, organizational pressures

to standardize health service delivery creates an institutional workplace culture of task-orientedness and efficiency promotion. Clearly there is a dire need to question how professional practice initiatives such as trauma-informed care are being integrated into broader organizational structures.

In the same vein of trauma-informed care, a difference was noted where PHNs within the CGT study described processes centered around protecting women from being re-traumatized. Nurses within the JBI study did not mention this goal within care provision and rather focused on ways to address barriers such as language, culture and social isolation. The focus of protection among PHNs within the CGT study can be attributed to their awareness of stress and trauma as being triggered by a health system that is confusing, challenging to navigate, and at times embedded with stigma and discrimination. These findings add to current understandings of structural discrimination that leads to further traumatization among racialized women (Varcoe, et al., 2014). Despite health systems focus on placing responsibilities for staying healthy post-migration on women, PHNs in this CGT study focused on social context where exposure to trauma was assumed and awareness of power relations within health care systems were attended to. This aligns with Varcoe et al.'s (2014) call to actively engage in respectful relationships with women forcibly pushed into experiences of health inequity and social exclusion.

Questioning Access to Care. Another difference noticed within the JBI and CGT findings was the conceptualization of women not seeking antenatal care. Within the JBI findings, nurses were troubled by the prevalence of women forcibly displaced who did not seek antenatal care pre- and post-migration. PHNs within the CGT inquiry also pondered on how few refugee women were seen within their clinic. However, reasons provided for the limited pursuit of care focused on the weakened pulse PHNs had on the migrant population as well as the fractured

referral pathways that steered women toward PHN services. The reasons for limited antenatal care among women were described by nurses within the JBI systematic review as having decreased access to maternal health services within migration journeys due to conflict, war and violence. Much has been documented about the lack of access to maternal health needs along migration routes travelled by forcibly displaced women (Bahamondes et al., 2020; Grundy, et al., 2012; Janevic et al., 2011; Loyer, et al., 2014; Mullany et al., 2008). However, a paucity of inquiry on the structural barriers driving inequitable access to health among forcibly displaced women exists. Although the World Health Organization has encouraged promotion of equity through targeting structural injustices, focus seems to remain on how individuals should be accessing health. One example of an attempt to target structural barriers is within Babalola and Fatusi's (2009) work to understand determinants of access to maternal health services among Nigerian women. The authors discovered the need to work across individual, environmental and policy levels to target barriers to access and enhance maternal health. These findings support the need for contextualizing women's pre-migration and post-migration journeys in order to engage with inequities embedded within intersections of individual characteristics and broader socio-political forces that shape experiences of limited antenatal care.

Pre-migration contexts were alluded to within the JBI review findings where women's fear of nurses being connected to government officials was discussed. Fear was addressed through dialogue and clarification of the nursing role. While JBI findings included addressing fear, CGT findings did not. Possible explanations for this nuanced finding include the geographical proximity most studies within the JBI review had with conflict-ridden and/or environmentally unstable countries. Exposure to populations fearing deportation or fearing government due to histories of being governed by militant rulings may be more prevalent within

countries geographically bordered by unsettling issues such as war. For example, Nellums et al. (2021) reveal how women with precarious migrant statuses experience fear and anxieties related to perceived risks of being deported through accessing health services. Other studies have pinpointed fear of deportation to restrictive and tyrannical migration policies that limit access to health (Larchanche, 2012; Munyewende et al., 2011).

Implications for Nursing

Within this section, I describe implications of my dissertation according to education, professional practice and future research domains which have potential for impacting broader health systems. Implications to policy are integrated within these three domains. Situating forcibly displaced mothering women within nursing within my dissertation occurred through two methodological approaches and revealed findings upon which I built these implications. From an education approach, I advise building capacity of nurses in understanding and integrating migration as a health determinant through proposing a curricular framework. From a professional practice approach, I recommend nurses staying informed on migrant health policies and how they impact women's health. Recommendations are also made to examine organizational and structural integration of trauma informed care. Finally, from a research approach, I discuss implications related to the erosion of public health nursing, the challenges of language barriers in caring for forcibly displaced women, and further inquiry needed related to trauma-informed care.

Education

It was evident within this dissertation that integrating migrant status as a health determinant into care provision was implicit. Minimal guidance was available for nurses to inform their practice. Nonetheless, nurses drew on their capacities to locate inequities stemming from migrant policy.

A clear implication was thus building on nurse capacities to better understand how migrant status impacts women's health.

Building capacity can include integrating migrant health education that analyzes migrant status as a health determinant into nursing education curriculum as well as professional practice to better inform nursing care provision. From a curriculum development perspective, looking at the history of migration and the root causes of forced displacement would open up understandings of diverse contextualities. For example, while being forcibly displaced has historically been associated with war, involuntary migrants displaced due to climate change and environmental factors have been overlooked (United Nations,2019). The topic of populations forcibly displaced by climate change has received little attention with the past several years of environmental debates (McDonnell, 2018). Approaching such exploration from an intersectionality lens, forced migration can be examined for links to distinct health impacts and how gender, race and migrant status shape health experiences. How health is further impacted by broader international, national and local structures such as policies would be a critical approach to curriculum development. To further this notion of integrating migration as a health determinant within education, I drew upon the Canadian Association of Schools of Nursing's (2015) National Nursing Education Framework in the following table (see Table 3). It is a proposal of a curriculum framework for engaging with migrant health in nursing education and can be built upon as a Baccalaureate, Masters and/or Doctoral outline.

Table 3: Proposed Curriculum Framework for Engaging with Migrant Health in Nursing

Domain 1: Knowledge
Baccalaureate/Masters/Doctoral

Guiding Principle:

To provide a broad knowledge base in migrant status as a social determinant of health

Essential Components:

Students will be prepared to demonstrate...

1.1 Knowledge of the history of migration, the development of migrant discourse at national and international levels and the development of key global pillars supporting forcibly displaced populations

1.2 Understand the differences between the varying migrant categories and explore associated health impacts

1.3 Knowledge of the linkages between colonialism and citizenship and the effects on health

1.4 Knowledge of the diverse contexts of forced migration

1.5 Knowledge of the health and legal intersections that shape forcibly displaced populations nationally and internationally including critical engagement with relevant policies affecting migrant health

Domain 2: Research, Methodologies, Critical Inquiry & Evidence

Baccalaureate/Masters/Doctoral

Guiding Principle:

To foster critical thought and inquiry into how migrant status intersects with gender, race, class... to impact health

Essential Components:

Students will be prepared to demonstrate...

2.1 the ability to seek and critically interpret a broad range of information, evidence and practice from diverse perspectives and analyze the guiding principle

- 2.2 the ability to understand diverse theoretical approaches to inquiring into migrant health
- 2.3 the ability to engage with intersectionality as a lens that examines inequities embedded within the interplay of micro, meso and macro structures
- 2.4 the ability to understand and critique current migrant health approaches to healthcare provision (eg: cultural competence/safety; trauma-informed care)
- 2.4 the ability to engage in the ethics of inquiring into migrant health research and practice

Professional Practice

Similar to my suggested implications is Pottie et al's (2014) response to the need for improved health care delivery for vulnerable migrants. These authors recommend staying up to date on advances in medicine and health care provision. However, I extend the recommendation to include staying apprised with the impacts of intersecting policies on migrant status and health. On-going professional practice updates would be framed through intersectionality as a heuristic (Collins, 2019) which allows dialogue on assumptions underpinning federal and provincial migration policies and how they affect access to health among forcibly displaced women. Through this intersectional lens, professional practice approaches would dive deeper into re-thinking common problems of inequity PHNs see within their practice.

Trauma-informed care was another area within this dissertation where implications can be drawn from. Increased professional practice support related to understanding trauma-informed care among women with precarious migrant status was identified across both inquiries. Doing so would mean an organizational effort toward bridging trauma-informed care principles with practical strategies. Wider implications that target organizational prioritization of trauma-informed care among complex populations such as refugee women are necessary according to findings within this dissertation. Many initiatives already exist (see Table 4). As exemplified in

this table, trauma-informed care initiatives have taken hold across community and broader systems levels. One such initiative from a community perspective is the Atira Women’s Resource Society (Atira Women’s Resource Society, 2021) serves women across lower mainland British Columbia in providing accessible safe housing. Central to this organization’s policy structure is acknowledgement of women as having been exposed to trauma and violence. Resulting outcomes of this structural integration included employing women with social justice intentions and/or with past experiences of trauma, violence and homelessness to create relatable, meaningful connections with women in need of support.

Table 4: Trauma-Informed Care Initiatives

Nursing	<p><u>Canadian Nurses Association (n.d.)</u>: trauma-informed care related to substance use is alluded to as a set of principles to be applied within health organizations.</p> <p><u>British Columbia College of Nurses & Midwives (2013)</u>: entry-level to nursing competencies include using principles of trauma-informed care that prioritize survivor’s safety, choice and control. Healthcare systems and providers are required to participate in trauma-informed practice principles to promote destigmatizing mental health associated to trauma and violence exposure.</p> <p><u>Perinatal Services British Columbia (2014)</u>: Provincial perinatal guidelines on population and public health prenatal care pathways include integration of trauma and violence informed care. Highlighted within this approach is prevention of further (re)traumatization through experiences of powerlessness and loss of control.</p>
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Community	<p><u>Affiliation of Multicultural Societies and Services Agencies of British Columbia (2020)</u>: lists national and international resources focused on trauma informed practice</p> <p><u>DiverseCity Community Resources Society (n.d.)</u>: Refugee response team Fraser Valley – Information sheet supporting refugee clients who have experiences trauma. Provides a comprehensive guide to supporting trauma-informed services.</p> <p><u>Vancouver Association for Survivors of Torture (2020)</u>: dedicated group of volunteers working within one of BC’s largest center for refugee mental health. Offers extensive regarding trauma informed practice approaches to working with refugees. Training recipients include Vancouver School Board, Immigrant Services Society of BC, Canadian Mental Health Association British Columbia, University of British Columbia and Mosaic BC.</p> <p><u>Atira Women’s Resource Society (2021)</u>: a community organization serving women across lower mainland British Columbia that integrates trauma-informed principles structurally to ensure organizational commitment.</p>
Health Systems	<p style="text-align: center;">PROVINCIAL</p> <p><u>Fraser Health Authority (2019)</u></p> <p>Embedded within the Fraser health mental health and substance use clinical policies: Family and natural supports inclusion and support policy is a</p>

trauma informed practice emphasis where trauma is defined as universal.
Avoiding traumatizing and/or re-traumatizing is also highlighted.

BC Mental Health & Substance Use Services (2021)

Drawing from the Substance Use and Mental Health Services

Administration trauma-informed practice framework, guidance is integrated in practice manuals and resources are provided. Examples of integration into BC programs are given.

Government of British Columbia (2017)

Healing Families, Helping Systems: A trauma-informed practice guide for working with children, youth and families developed by the Centre of Excellence for Women's Health in collaboration with the Delegated Aboriginal Agencies and the Ministry of Children and Family Development. The guide, webinars and resources provided target practitioners, caregivers and care providers to inform practice.

NATIONAL

Public Health Agency of Canada (Government of Canada, 2018)

Trauma and violence-informed approaches to policy and practice outlines a recognition between violence and trauma and the associated health impacts. Key policy and principle integration is emphasized which draws on the British Columbia Provincial Mental Health and Substance Use Planning Council's (2013) Trauma-Informed Practice Guide.

Mental Health Commission of Canada (2014)

	<p>Webinar slides on creating a trauma-informed system and expectations of such a system on the service providers within it. Identifies trauma as circumstances that are unpredictable, unpreventable and could not be escaped. Assumes service providers and organizations as perpetually re-traumatizing people causing harm and impeding wellness.</p>
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While nursing associations provided guidance related to trauma-informed care frameworks including integration of principles within mandatory competencies, the larger national nursing association’s integration was far less (Canadian Nurses Association, n.d.). However, the British Columbia College of Nurses and Midwives (2021) alludes to the requirement of healthcare systems to participate in trauma-informed practice principles which involves provision of promising pathways toward healing. Inquiry into how professional practice structures located within health systems reflect this requirement is necessary to ensure nurses are supported in mindfully carrying out trauma-informed principles.

Further Research

With the JBI and CGT study findings pointing to nurses experiencing discomfort and unfamiliarity with women’s experiences of trauma and violence, further examination of how trauma-informed care is integrated into care provision is necessary. As discussed above, this finding is supported in the literature where many nurses are challenged by how to integrate trauma-informed care principles into daily practice (Hall et al., 2016; Muskett, 2014). While point of care understanding of trauma-informed care is touched on in my CGT study, it would be beneficial to understand how organizations have shifted their policies and paradigms to integrate trauma-informed care principles. As other scholars have identified (Bloom, 2010, Marcellus, 2014, Stokes et al., 2017), trauma-informed care should be an organizational endeavour rather

than a simple delivery of theory that is expected to rest on solely the shoulders of those delivering care.

Integration of migration as a social determinant of health has been recommended within the findings of this dissertation. While I have recommended curricular integration from a nursing education perspective, further research is needed on how health policy can support informing system uptake and application of migration as a health determinant. Canadian policy is informed by the Public Health Agency of Canada (PHAC) which is a national health portfolio funded by the Government of Canada (Government of Canada, 2021). Through drawing on Mikkonen and Raphael (2010), the PHAC prioritizes 14 social determinants of health that address the Canadian context. Notably, migration is not included within this list of determinants. These determinants stem from a 2002 York University Conference held in Toronto, Ontario and are discussed as having strong impacts on Canadian health (Mikkonen & Raphael, 2010). To address the antiquated nature of leaning on these determinants without questioning the impact of globalization on Canadian demographics and health needs, I recommend a long overdue intersectionality-framed critical analysis of the PHAC's uptake of health determinants and how they address forcibly displaced migrants.

Findings within this dissertation echo a commonly voiced issue faced by nurses as well as forcibly displaced women: the experience of language barriers. Implications that can be drawn from findings include further studying facilitators and barriers in using interpreter services. Although working with translators was seen as positive, there were questions of safety, confidentiality and timely accessibility that need further understanding. For example, what processes are being used within health organizations to protect women who are linguistically diverse from being further pushed into unsafe situations including being re-traumatized or

misunderstanding health information. Such an inquiry could integrate women's experiences of facilitators that fostered communication to inform organizational processes and policies. Building on my dissertation findings, innovative ways to reach across language barriers within varying healthcare provision contexts such as visual aids and smartphone applications need to be explored. Harnessing technology to assist with translation can provide lower-cost options for institutions (Al Shamsi et al., 2020). However, nurses within my systematic review findings described issues of mistranslation and misunderstanding information when using Google Translate to assist with interpretation. Although smartphones are an accessible tool, caution must be used and processes for translation within institutions constructed that integrate ethical considerations.

Lastly, the erosion of public health nursing has been well-cited within the literature (Aston et al., 2015; Cohen & McKay, 2010; Marcellus & Shahram, 2017; Schofield et al., 2011). The findings within this dissertation build on current literature by demonstrating the impacts of a waned PHN role on mothering women who have been forcibly displaced. Implications of this finding include research that analyzes structures impacting referral pathways and impeding access to PHN services. This would include exploring women's perspectives of accessing PHN services and exploring their processes of engaging with care provision. Additionally, further inquiry into forces influencing organizational decision-making related to population and public health priorities is necessary. Findings within my dissertation also revealed how PHNs have capacity to make multi-level contributions and thereby bridge policymaking with point-of-care realities. Reciprocally, health leaders can have a better pulse when working directly with PHNs on the moral and ethical issues they face. Understanding PHN capacities and engaging in moral

distress among PHNs can strengthen workplace health and enhance safe and ethical care provision (Pauly et al., 2012).

Understanding the broader influences on organizational decision-making can target structures that overlook PHN capacities and ultimately perpetuate barriers faced by complex populations. Questions that come to mind include: What processes do health authorities use to determine PHN service provision? What broader forces shape organizational decision-making related to population and public health? While erosion of the PHN discipline has been occurring over time, PHNs have continued to work silently and invisibly within the roots of social justice and human rights. Most recent examples include a nurse reporting poor and substandard care provision to elderly patients and being reprimanded by their local nursing association (Sciarpelletti, 2020). Silencing of nurses through a professional regulatory body's disciplinary rules quickly came under scrutiny. However, although legal action against this nursing association was taken, interrogation of disciplinary rules were limited. How are nurses being supported in their calls for action on human rights and social justice? While we are guided by a code of ethics and stand upon pillars of advocacy, how are we promoted to employ activism? Conversely, prevalence of silence among nurses has also been met with strong advocates for nursing such as Kathy Hardill and Cathy Crowe who have immersed themselves in the politics of health in order to amplify vulnerable homeless populations' voices. For example, Hardill links working within the social determinants of health as inextricably connected to having political awareness (McCullough, 2016). In other words, to make inequities visible and dismantle structures that promote inequity, multilevel political advocacy needs to be, and already is, a role within public health nursing. How organizations pay heed to this role within efforts to promote health equity is where further inquiry is needed.

Knowledge Translation

Choosing to do a publication-based dissertation aligned with my pragmatic-orientations where I wanted to ensure findings were made accessible and utilizable. However I realized during my participation in the research processes as well as within my process of writing the above chapters that further engagement with these intentions is needed through employment of a knowledge translation (KT) framework. Although this KT endeavour is not incorporated into my scholarship package, it is a commitment I made to ensure findings within this dissertation are disseminated in a thoughtful, robust way. Drawing on the Canadian Institute of Health Research (CIHR) end-of-grant knowledge translation plan worksheet (CIHR, 2015), I have started mapping a dissemination path that targets audiences including nurses, health leaders, researchers and policy makers. One KT endeavour involves writing an evidence summary of my JBI findings within the *International Nursing Review*, the official journal of the ICN. My goal is to engage with ICN to build on position statements toward integrating migration as a social determinant of health linking trauma-informed care with complex populations such as forcibly displaced women. Such integration would foster engagement with trauma-informed care as essential to care provision among involuntary migrants. Another article I have started writing engages with the impacts of PHN's eroded discipline. Intentions of this article are to make visible the insights PHNs have in working within structural constraints. How the erosion of a discipline has led to the weakening of community development and having a pulse on the health needs of complex populations will be focused on in this article.

While my goal is to partner with the PHN manager and sponsor who assisted me in gaining access to participants for my CGT study, the current pandemic state has created a barrier where priorities for most if not all PHNs and community health leadership are currently centered

on COVID-19 initiatives. However, this door has not closed. My aim is to continue nurturing this relationship and include KT activities with knowledge users including PHNs and health authority leadership.

Additional KT strategies include conference presentations and web-based activities. Although many in-person conferences have been postponed until 2022 due to COVID-19, some have been shifted to web-based formats. The International Institute for Qualitative Methodology will hold its annual Thinking Qualitatively conference in July 2021. In partnering with my supervisor, Dr. Lenora Marcellus, I have submitted an abstract that will highlight the implementation of the research design where intersectionality as an analytical tool was applied within the CGT methodology. In this presentation, experiences and insights will be shared in how this design was used to describe processes used by PHNs in their work with mothering refugee women and how intersectionality provided a unique heuristic to my analysis. Conferences being held in 2022 that I plan to submit abstracts to disseminate my dissertation findings include Perinatal Services BC's Healthy Mothers Healthy Babies conference, Community Health Nurses Canada conference, Canadian Association of Perinatal and Women's Health Nursing annual conference and the North American Refugee Health Conference.

Web-based KT activities that I have started engaging in include the development of a website, which will be an online platform for my research to be available and accessible. This endeavour will continue to evolve as I develop a program of research. Goals of this website include increasing awareness of forcibly displaced women's health issues through my publications and weekly blog. This is an ever-evolving area I aim to further construct. However, other web-based KT activities include social media such as Twitter, Facebook and LinkedIn. Twitter has been a productive way to engage with policymakers, researchers, community-based

and not-for-profit organizations, media and health system administrators. However, to engage with PHNs, I have found more casual platforms such as Facebook and LinkedIn as more successful. Connecting with forcibly displaced women has been challenging, especially during the current pandemic, as I have learned through my work as a research assistant with Dr. Joyce O'Mahony and Dr. Nancy Clark, my doctoral committee members. However, the use of smartphone applications seems more promising (Dayha & Dryden-Peterson, 2017). WhatsApp, for example, is a free application that many forcibly displaced populations communicate through and spend limited financial resources on (UNHCR, 2016). This KT endeavour would require more inquiry into and holds promise in engaging this group of women in research and dissemination activities.

Conclusion

In thinking about concluding this dissertation work, I circle back to my initial reflections as I entered into my doctoral studies with the intention of shedding light on mothering women who were refugees and forcibly displaced. In doing so, I further conceptualized my central aim of situating this complex population within the nursing discipline and I engaged with my public health nursing background. Resulting from these conceptualizations were two distinct approaches that I worked within: a JBI systematic review of qualitative evidence that identified, critically appraised and synthesized literature addressing nurses experiences of providing care to maternal immigrant and refugee women, and; a CGT inquiry using intersectionality as an analytical tool that generated a basic social process on how PHNs Create Safe Relational Space in working toward trusting relationships with mothering refugee women while navigating structural forces.

Findings generated were written into publication-ready formats with two out of the four manuscripts already published. The first publication was a protocol for the JBI systematic review and the second publication centered on a novel research design. Using intersectionality within my CGT study oriented focus on broader structural contentions that shape PHN work with complex populations. Forcibly displaced women was the population I focused on with participants, however it was discovered that although PHNs worked passionately with these women, they were concerned about the fragmented system within which women had to navigate to locate health services. Diminished funding and organizational re-prioritization were among the broader reasons PHNs described as affecting how PHNs entered into relationships with refugee women. The passion PHNs had for working with complex populations was resounding. PHNs demonstrated strategies they employed to protect women from further structural harm. However, PHNs hands were tied by program constraints. It was the letting go of those women who were still encountering challenges that created frustration and moral distress. Implications were discussed and included the need for further inquiry into how migrant status is integrated into health systems as a health determinant. Additionally, analysis of migrant and health policy intersections is needed to understand what fosters and inhibits access to health services among forcibly displaced women.

Consistent within findings of both inquiries within this dissertation was the need for further integration of trauma-informed care within nursing. This includes the multiple contexts of nursing practice where women seek health services. As recommended within my JBI review, nurses need on-going support and education related to the health impacts of pre-migration exposure to trauma and violence. More work is needed in analysing how organizations are integrating trauma-informed care to structurally support nurses in their work.

While ideologies of individualism and corporatism emerged as deep-rooted influences to issues of limited resources, mounting workloads and frequent organization reshuffling of priorities, this study also exposed how nurses engaged in experiential learning underpinned by social justice. Situating forcibly displaced women within nursing is a continuous effort that requires further scholarship and bridging with policy, education and leadership. Moreover, it requires collaboration with health leaders and knowledge users as well as persistent scrutinization of guiding texts and policies. As nurses, we have the insights and capacities to link the realities of complex populations to the development and evolution of policies that shape healthcare provision. It behoves us to continue our nursing stewardship while also shedding light on the voiceless.

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movement-is-a-challenge-for-refugees-and-migrants-as-well-as-for-the-receiving-
population/migration-and-health-key-issues.

Appendix A: Recruitment Brochure



Public health nurses in the community
<https://www.communitypractitioner.ca.uk/news/2018/01/scotland-family-nurse-partnership-expand>

Project Overview

- Voices of public health nurses (PHNs) lack in refugee health literature
- The PHN voice is important to facilitate promotion of health and equity among complex populations
- I propose a qualitative study exploring PHN experiences of supporting refugee mothers in the community

Who We Are

Co-Investigator

Shahin Kassam, RN, BN, MN
 PhD Nursing student
 University of Victoria
shahin@uvic.ca

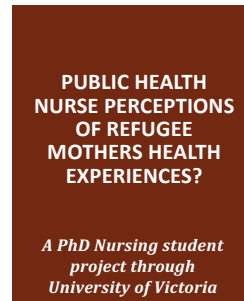
Principal Investigator

Dr. Lenora Marcellus, RN, PhD
 Associate Professor
 School of Nursing
 University of Nursing

Supervisory Team

Dr. Nancy Clark, RN, PhD
 Assistant Professor
 School of Nursing
 University of Nursing

Dr. Joyce O'Mahony, RN, PhD
 Associate Professor
 School of Nursing
 Thompson River University



Refugee mothers experience higher mental health concerns than the general population

Project Overview

- 52.3% of refugees are women and girls. Many of these women are childbearing age or already mothering.
- Public health nurses (PHNs) are among the first healthcare providers to work with refugee women in the community. However, little is known about how PHNs contribute

Next Steps:

- Recruitment of PHNs working in various roles
- Interview PHNs

PHNs have always played a role in supporting families whose health is affected by social or economic conditions...
Browne et al., 2010, p.27

Research Approach

Constructive grounded theory is the qualitative methodology that will be used to generate theory created by participants

The Question...

What are the experiences of refugee mothers from the perspective of Public Health Nurses?

SELECTED REFERENCES:

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Appendix B: Initial Interview Guide

Interview Guide

Is there anything within the consent form you had questions about? Please sign and return to me.

Preferred contact method? Email? – email and phone are fine phone is quicker response

My name is Shahin Kassam and I am the researcher for this study as outlined in the brochure I gave you. As you may know, I'm studying how public health nurses understand refugee mothers experiences of health. Now that we have reviewed the consent form, we will begin our [group] discussion. If at any time during our discussion you have any questions, please feel free to let me know.

1. How long have you been public health nursing? (years of experience) 2003; 17 years
2. How long have you worked with refugee mothers? (What drew you to working with them?)
3. How are refugee mothers referred to you?
4. How is caring for refugee mothers unique or different from caring for other groups of mothers with different vulnerabilities?
5. Some PHNs have talked about identifying/recognizing trauma within their work with refugee mothers– what have your experiences been?
6. In some interviews, a few PHNs have talked about fostering and supporting refugee mothers toward being able to access healthcare 'like everyone else does' – can you tell me your thoughts on this goal?
7. What advice would you have for a PHN just starting to work with refugee mothers?
8. Is there anything else about your work with refugee mothers that I forgot to ask you?

Thank you! I will now analyze this interview and integrate it into the other data I've collected. If any questions come up can I contact you again? If there is anyone else who you know within the NFP please give them my info to connect with me.

**Appendix C: Amended Expert Interview Informed Consent Form Due to
COVID-19 Pandemic**



Informed Consent Form for Qualitative Research: Expert Interview

Title of Study: How Do Public Health Nurses Come to Understand Refugee Mothers Health Experiences?

Principal Investigator: Dr. Lenora Marcellus, RN, BSN, MN, PhD
University of Victoria
[250-472-5428](tel:250-472-5428)

Co-Investigators: **Shahin Kassam, RN, BN, MN, PhD (c)**
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shahin@uvic.ca

Dr. Nancy Clark, RN, PhD
University of Victoria
250-472-4703

Dr. Joyce O'Mahony, RN, PhD
Thompson Rivers University
250-377-6138

Hemi Shreshta, RN, BN
Fraser Health Population & Public Health
604-587-4749

INTRODUCTION AND STUDY PURPOSE

My name is Shahin Kassam and I am a PhD in Nursing candidate from the University of Victoria School of Nursing. This study you are invited to participate in is part of my student research project. This consent form may have words that need clarification or create questions for you. Please stop me at any time during our time together and we can discuss your questions.

The focus of this qualitative study is on understanding how **Public Health Nurses (PHNs) and retired PHNs** come to understand and support maternal refugee women and their experiences of access to mental health services. You are invited to participate in this study to explore your thoughts and perspectives on this topic.

Refugee mothers have challenges accessing mental health services. Among the first healthcare providers to work with refugee mothers are PHNs. Social determinants of health and equity are underlying concepts to the work PHNs do in the community. This study looks into how PHNs **and retired PHNs** come to understand access needs among pregnant and mothering refugee women with mental health issues. The purpose of this study is to understand PHNs perspectives on factors they face when providing care and support to refugee mothers.

YOUR PARTICIPATION IS VOLUNTARY

You are being invited to participate in this research because of your knowledge as a PHN and your experience with working with refugee mothers in the community. Your participation is entirely voluntary, meaning it is your choice whether or not to take part in this study. If you decide to voluntarily participate in this research, you will be asked to sign this form which includes agreeing to participate in an interview discussion which will be audio-taped. You are free to withdraw from this study at any time without giving reasons for your decision. If you decide not to take part in this study, you do not have to provide any reason for your decision not to participate.

WHAT DOES THE STUDY INVOLVE?

This interview will entail the following:

- Expert interview format
- approximately one hour
- **Will take place either over the phone or using a videoconferencing platform of your choice**
- Interview discussion will be audio-taped
- I will be collecting all data and conducting all analyses of this data
- To clarify my findings, I may need to ask you follow-up questions at a later date
- Knowledge that is generated through this research will be shared and checked for authenticity with all participants during and after data analysis.

WHAT ARE THE POSSIBLE RISKS AND INCONVENIENCES OF PARTICIPATING?

Anticipated risks to this study are considered minimal. Questions you will be asked will be in the context of your everyday practice. Wellness resources for support will be offered if the need arises. You are free to not answer any questions that you do not want to answer.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?

This type of research is important to understand issues of equity through PHNs and retired PHNs perspectives. In addition, the intention of this research is to highlight PHNs voices. With PHNs having capacity to influence practice and policy, this research holds promise to enhancing health experiences of refugee mothers with mental health concerns. Anticipated benefits include an opportunity to contribute to generating findings that integrate your perspectives. With public health nurses often working in isolation and independently within communities, this research endeavor will provide a chance to contribute to influencing policy, practice, research and education initiatives. Refugee mothers will potentially benefit from this research through the effects of generated findings.

WHAT HAPPENS IF I DECIDE TO WITHDRAW MY CONSENT TO PARTICIPATE?

Your participation in this research is entirely voluntary. This means you may withdraw from this study at any time without providing explanations. If you decide to enter the study and later withdraw, there will be no penalty or consequences. Withdrawal from this study will entail removal of all data that you have provided.

AFTER THE STUDY IS FINISHED

Data will be retained for five years post-publication of study. After five years, all data will be destroyed by erasing the memory sticks, erasing all computer files and shredding all notes and memos. Results will be shared through conference presentations, publishing of my dissertation and publishing of any articles that result from this study. Preservation of your identity will be attended to through use of pseudonyms and omission of employment identifiers.

WHAT WILL THE STUDY COST ME?

This study will occur at a time of your choice. Provision of coffee and tea as well as snacks will be offered to reflect your time and commitment to this study.

WILL MY TAKING PART IN THIS STUDY BE KEPT CONFIDENTIAL?

Your confidentiality will be respected. However, research records identifying you may be inspected in the presence of the Investigator or her designate by representatives of the Fraser Health Research Ethics Board for the purpose of monitoring the research. No information or records that disclose your identity will be published without your consent, nor will any information or records that disclose your identity be removed or released without your consent unless required by law.

Confidentiality will be managed in the following ways:

- No other members of my PhD supervisory committee will have access to your identity or to the raw data
- Your name and employer will be omitted and altered in all documentation

- All data from interviews will not reveal your identity
- Data will be stored on encrypted and password protected computerized files including audio recordings
- Audio recordings will be deleted right after they have been transcribed
- Password-protected transcription files will be backed up on a memory stick which will be stored in a locked filing cabinet in the my (Shahin Kassam's) home office
- Data involving participant contact information needed for follow up will be destroyed once recruitment is complete; consent forms with participant names and contact information will also be destroyed after study completion
- Research participant names will be anonymized through use of codes during data collection and analysis
- After the research study is complete, pseudonyms will be used to continue the protection of participant anonymity

Audio Taping

Audio-recording our interview is a method I am using to capture all ideas and words within our discussion. These are important to capture and difficult to recall without the use of audio-recording. Thus, part of consenting to participating in this study is giving permission for me to audio-record our conversation. Quotations from this conversation may be published as part of our findings of this study.

WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT THE STUDY DURING MY PARTICIPATION?

If you have any further questions or desire further information about participating in this study before or during participation, I can be reached any time through email at shahin@uvic.ca or through calling me at 778-228-8020.

WHO DO I CONTACT IF I HAVE ANY QUESTIONS OR CONCERNS ABOUT MY RIGHTS AS A PARTICIPANT DURING THE STUDY?

By signing this consent form, you are not giving up any of your legal rights. If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Fraser Health Research Ethics Board (REB) co-chairs by calling 604-587-4681. You may discuss these rights with one of the co-chairs of the Fraser Health REB.

Title of Study: How Do Public Health Nurses Come to Understand Refugee Mothers Health Experiences?

CONSENT TO PARTICIPATE

After signing this form, a copy of this consent will be left with you, for your future reference.

In signing this consent form:

- I have had the opportunity to ask questions about the information provided and have had satisfactory responses to my questions
- I understand that my participation in this study is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time
- I understand that I am not waiving any of my legal rights as a result of signing this consent form
- I have read this form and I freely consent to participate in this study
- I have been told that I will receive a dated and signed copy of this form
- I consent to allowing you to audio-tape our interview
- I consent to being contacted during data analysis for further questions, for clarifications needed, for updates on the research process, and for hearing about this study's findings

Print Name of Participant _____

Signature of Participant _____

Preferred contact information (email, phone, both, other) :

Date _____
Day/month/year

Print Name of person administering consent _____

Signature of person administering consent _____

Date _____
Day/month/year

Appendix D: Focus Group Informed Consent Form

Informed Consent Form for Qualitative Research: Focus Group ³

Title of Study: How Do Public Health Nurses Come to Understand Refugee Mothers Health Experiences?
--

Principal Investigator: Dr. Lenora Marcellus, RN, BSN, MN, PhD
University of Victoria
[250-472-5428](tel:250-472-5428)

Co-Investigators: **Shahin Kassam, RN, BN, MN, PhD (c)**
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Dr. Joyce O'Mahony, RN, PhD
Thompson Rivers University
250-377-6138

Hemi Shreshta, RN, BN
Fraser Health Population & Public Health
604-587-4749

INTRODUCTION AND STUDY PURPOSE

My name is Shahin Kassam and I am a PhD in Nursing candidate from the University of Victoria School of Nursing. This study you are invited to participate in is part of my student research project. This consent form may have words that need clarification or create questions for you. Please stop me at any time during our time together and we can discuss your questions.

The focus of this qualitative study is on understanding how Public Health Nurses (PHNs) come to understand and support maternal refugee women and their experiences of access to mental health services. You are invited to participate in this study to explore your thoughts and perspectives on this topic.

³ Drawn from Fraser Health Authority. (2018). Research forms, guidance notes and templates. Retrieved from: <https://www.fraserhealth.ca/employees/research-and-evaluation/find-resources/research-forms-guidance-notes-templates>.

Refugee mothers have challenges accessing mental health services. Among the first healthcare providers to work with refugee mothers are PHNs. Social determinants of health and equity are underlying concepts to the work PHNs do in the community. This study looks into how public health nurses come to understand access needs among pregnant and mothering refugee women with mental health issues. The purpose of this study is to understand PHNs perspectives on factors they face when providing care and support to refugee mothers.

YOUR PARTICIPATION IS VOLUNTARY

You are being invited to participate in this research because of your knowledge as a PHN and your experience with working with refugee mothers in the community. Your participation is entirely voluntary, meaning it is your choice whether or not to take part in this study. If you decide to voluntarily participate in this research, you will be asked to sign this form which includes agreeing to participate in focus group discussion which will be audio-taped. You are free to withdraw from this study at any time without giving reasons for your decision.

If you decide not to take part in this study, you do not have to provide any reason for your decision not to participate.

WHAT DOES THE STUDY INVOLVE?

This interview will entail the following:

- focus group format involving approximately 5 to 10 PHNs from the health unit you work within
 - approximately one hour
 - Will take place at a location and time chosen by the group of PHNs
 - Focus group discussion will be audio-taped
 - I will be collecting all data and conducting all analyses of this data
 - To clarify my findings, I may need to ask you follow-up questions at a later date
- Knowledge that is generated through this research will be shared and checked for authenticity with all participants during and after data analysis.

WHAT ARE THE POSSIBLE RISKS AND INCONVENIENCES OF PARTICIPATING?

Anticipated risks to this study are considered minimal. Questions you will be asked will be in the context of your everyday practice. Wellness resources for support will be offered if the need arises. You are free to not answer any questions that you do not want to answer.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?

This type of research is important to understand issues of equity through PHNs perspectives. In addition, the intention of this research is to highlight PHNs voices. With PHNs having capacity to influence practice and policy, this research holds promise to enhancing health experiences of refugee mothers with mental health concerns. Anticipated benefits include an opportunity to

contribute to generating findings that integrate your perspectives. With public health nurses often working in isolation and independently within communities, this research endeavor will provide a chance to contribute to influencing policy, practice, research and education initiatives. Refugee mothers will potentially benefit from this research through the effects of generated findings.

WHAT HAPPENS IF I DECIDE TO WITHDRAW MY CONSENT TO PARTICIPATE?

Your participation in this research is entirely voluntary. This means you may withdraw from this study at any time without providing explanations. If you decide to enter the study and later withdraw, there will be no penalty or consequences. Withdrawal from this study will entail removal of all data that you have provided.

AFTER THE STUDY IS FINISHED

Data will be retained for five years post-publication of study. After five years, all data will be destroyed by erasing the memory sticks, erasing all computer files and shredding all notes and memos. Results will be shared through conference presentations, publishing of my dissertation and publishing of any articles that result from this study. Preservation of your identity will be attended to through use of pseudonyms and omission of employment identifiers.

WHAT WILL THE STUDY COST ME?

This study will occur at a time chosen by the PHN group participating in this focus group. Provision of coffee and tea as well as snacks will be offered to reflect your time and commitment to this study.

WILL MY TAKING PART IN THIS STUDY BE KEPT CONFIDENTIAL?

Your confidentiality will be respected. However, research records identifying you may be inspected in the presence of the Investigator or her designate by representatives of the Fraser Health Research Ethics Board for the purpose of monitoring the research. No information or records that disclose your identity will be published without your consent, nor will any information or records that disclose your identity be removed or released without your consent unless required by law.

Confidentiality will be managed in the following ways:

- No other members of my PhD supervisory committee will have access to your identity or to the raw data
- Your name and employer will be omitted and altered in all documentation
- All data from interviews will not reveal your identity
- Data will be stored on encrypted and password protected computerized files including

audio recordings

- Audio recordings will be deleted right after they have been transcribed
- Password-protected transcription files will be backed up on a memory stick which will be stored in a locked filing cabinet in the my (Shahin Kassam's) home office
- Data involving participant contact information needed for follow up will be destroyed once recruitment is complete; consent forms with participant names and contact information will also be destroyed after study completion
- Research participant names will be anonymized through use of codes during data collection and analysis

After the research study is complete, pseudonyms will be used to continue the protection of participant anonymity

Audio Taping

Audio-recording our interview is a method I am using to capture all ideas and words within our discussion. These are important to capture and difficult to recall without the use of audio-recording. Thus, part of consenting to participating in this study is giving permission for me to audio-record our conversation. Quotations from this conversation may be published as part of our findings of this study.

WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT THE STUDY DURING MY PARTICIPATION?

If you have any further questions or desire further information about participating in this study before or during participation, I can be reached any time through email at shahin@uvic.ca or through calling me at 778-228-8020.

WHO DO I CONTACT IF I HAVE ANY QUESTIONS OR CONCERNS ABOUT MY RIGHTS AS A PARTICIPANT DURING THE STUDY?

By signing this consent form, you are not giving up any of your legal rights. If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Fraser Health Research Ethics Board (REB) co-chairs by calling 604-587-4681. You may discuss these rights with one of the co-chairs of the Fraser Health REB.

Title of Study: How Do Public Health Nurses Come to Understand Refugee Mothers Health Experiences?

CONSENT TO PARTICIPATE

After signing this form, a copy of this consent will be left with you, for your future reference.

In signing this consent form:

- I have had the opportunity to ask questions about the information provided and have had satisfactory responses to my questions
- I understand that my participation in this study is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time
- I understand that I am not waiving any of my legal rights as a result of signing this consent form
- I have read this form and I freely consent to participate in this study
- I have been told that I will receive a dated and signed copy of this form
- I consent to allowing you to audio-tape our interview
- I consent to being contacted during data analysis for further questions, for clarifications needed, for updates on the research process, and for hearing about this study's findings

Print Name of Participant _____

Signature of Participant _____

Preferred contact information (email, phone, both, other) :

Date _____
Day/month/year

Print Name of person administering consent _____

Signature of person administering consent _____

Date _____