JBI

BEST PRACTICE

Evidence-based information sheets for health professionals

Experiences of nurses caring for involuntary migrant maternal women

Recommendations*

- The impact of migrant policies on the health of involuntary migrant women should be integrated into nursing education curriculum and ongoing professional development across acute and community professional practice. This includes teaching nurses how to assess migrant status, and how the status contributes to barriers among women accessing health services. **(Grade A)**
- Providing nurses with ongoing education and support related to the integration of trauma and violence-informed care within practice is recommended. Organizations can assist with this by developing policies that include administrative support to facilitate nurses' ability to provide continuity of care. Initiatives should aim to promote disclosure of trauma and violence exposure among migrant maternal women and to prevent their disengagement with health care systems. **(Grade A)**
- Exploring innovative strategies to overcome language barriers between migrant women and nurses in acute and community health contexts when interpreter services are unavailable, or when the woman does not feel comfortable with the interpreter, is advised. Examples include visual aids and body language. Risks associated with using family members as translators need to be integrated within policy development. **(Grade A)**
- To ensure the safe provision of care, clinical pathways should address the complexity of health issues experienced among involuntary migrant maternal women. This includes the need for timely health follow-up and close monitoring due to minimal antenatal care, and the need for interdisciplinary partnerships to streamline care and facilitate access to services. **(Grade A)**

**Definition of JBI's Grades of Recommendation*

Information source

This Best Practice Information Sheet is a summary of evidence derived from a systematic review published in 2022 in JBI Evidence Synthesis.[1]

Background

Involuntary migration is a global phenomenon stemming from multiple humanitarian crises including war and environmental disasters. Those who migrate involuntarily are forcibly displaced from their home countries and seek safety from violence, trauma, and poverty. Over the past decade, more than 100 million people worldwide have involuntarily migrated from their homes. Half of this population consists of women and girls, most of whom are of childbearing age.

The definition of mothering includes women experiencing the processes of childbearing, birthing, and/or post-birth where infants are up to 6 weeks of age. Based on this concept and on the World Health Organization's conceptualization of maternal health, the term "involuntary migrant maternal women" refers to women living with forcibly displaced migrant status and experiencing mothering processes. Forcibly displaced migrant categories are dependent upon the host country's network of migrant policies. Examples of such involuntary migrant status categories include refugee, internally displaced, and/or stateless.

Women's maternal health is linked to their migration journeys and their migrant status. Most of these women experience health disparities including higher rates of mental health concerns, forms of abuse and violence, limited prenatal care, and diminished social support.

Cultural and linguistic barriers exacerbate these disparities. Nurses are uniquely educated and informed by health promotion and illness prevention principles to provide care to those affected by multiple complex health issues. Understanding the unique experiences of nurses who provide care to involuntary migrant maternal women can highlight the capacity nurses hold in attending to the health impacts of forced migration.

Objective

To present the best available evidence on the experiences of nurses providing care to involuntary migrant maternal women.

Phenomena of interest

This review considered studies that explored nurses' experiences of providing care to involuntary migrant maternal women. Understanding the multiple ways care is provided globally by nurses to meet the unique needs of this culturally and linguistically diverse population was a central interest. Rather than focusing on singular aspects of nursing practice, such as providing sexual and reproductive care, the general experience of care provision across diverse health care settings was explored.

Quality of the research

A total of 23 studies were included in the systematic review. Study designs varied from hermeneutic, ethnography, grounded theory as well as descriptive and exploratory qualitative designs. Data extracted included participant characteristics such as gender, migration history, and race/ethnicity. Methodological quality was assessed by two independent reviewers with all studies scoring 80% or higher in the 10-item checklist. Credibility of findings was high due to unequivocal findings (i.e., not open to challenge). Confidence in the synthesized findings was graded as moderate according to the ConQual approach.

Findings

Studies included in this review originated from varying countries including Canada, Australia, Finland, the United Kingdom, Switzerland, Sweden, Ireland, Norway, Bangladesh, Thailand and the United States. At least 186 nurses participated across the 23 studies. The precise number of nurses who participated is unknown, as six studies did not specifically identify the number of nurses included within their multidisciplinary samples. A total of 115 findings were generated from the 23 studies and aggregated into four categories. After further aggregation based on similarity of meaning, these four categories were grouped into two synthesized findings.

Synthesized finding 1: Nurses integrate cultural and linguistic diversity within practice

The first synthesized finding of the review involved how nurses integrated cultural and linguistic diversity into care provision through being sensitive to diverse health beliefs and ways of communicating health concerns. Some nurses described prejudiced attitudes among their colleagues. Many nurses expressed desire to understand how cultures affected women's maternal self-care practices. Adapting care delivery protocols to support cultural practices, prioritizing mothers' belief systems over their own, involving family members in care provision, and being open to learning new meanings of health practices were examples of how nurses employed cultural sensitivity. Consequences of integrating cultural sensitivity into practice included enhanced dialogue between women and nurses around issues many women were not accustomed to speaking about.

"*. . .I often ask them too 'What culturally would you do in your own country' so…my education level increases to. . . So find out what their normal is before trying to change it.*"

Nurses also integrated awareness of linguistic diversity within their care provision. Strategies that nurses used to address language diversity included partnering with other disciplines such as psychologists, social workers, and interpreters. Accessing translation services was described by some nurses as both beneficial and limiting. Nurses described solutions such as using visual aids and employing hand gestures and body language to facilitate communication within care provision. Nurses voiced caution in using Google Translate and family members as interpretation aids, which often led to mistranslation and misunderstanding of information as well as compromising women's confidentiality.

Synthesized finding 2: Nurses assess for inequities resulting from forced migration on maternal women

The second synthesized finding of the review conveyed how nurses assessed for inequities resulting from the impacts of forced migration on maternal women. Inequities included limited social supports, housing instability, and inadequate access to food and clothing. Health impacts seen by nurses included higher rates of mental health issues such as depression and anxiety. Migrant status was viewed as contributing to these inequities. Mitigation of inequities involved spending time on understanding how pre-migration experiences affected women's maternal health, as well as facilitating community integration to health and social systems. The notion of health systems was unfamiliar to most women due to having limited access to health services within war-torn countries. Although nurses described receiving little formal training on assessing migrant status, nurses recognized that most of these women have high-risk pregnancies and need specialized care pathways to meet their complex maternal health needs.

"They are all 'high-risk' women, so they all need high-risk, consultant-led care...most of them have had no bloods, no scans, no nothing. They could have twins, placenta praevia, thalassaemia, hepatitis B or hepatitis A... They need a proper care pathway."

Nurses expressed a lack of comfort with knowing how to engage in women's experiences of trauma and violence; however, they provided care centered on being attentive to women's emotional well-being during clinical appointments. Moreover, nurses prioritized establishing trusting relationships with women to promote disclosure of traumatic experiences, thus increasing women's engagement with health systems. Nurses found it challenging to establish trust with women from countries where health systems were tied to corrupt government structures. However, continuity of care and clarification of the nursing role and health systems were strategies that mitigated women's anxiety. Lack of organizational commitment to provide time and flexibility for care hindered nurses in their attempts to establish trusting relationships.

Conclusions

Three central areas within nursing practice that are critical to care provision for involuntary migrant maternal women were identified in this review. The first was understanding involuntary migrant status as a health determinant. In engaging with the involuntary migrant status of a maternal woman, nurses revealed health issues such as diminished access to prenatal care and social isolation. Nurses described these issues as stemming from a woman's migrant status despite understanding little about involuntary migrant categories. Secondly, many nurses described involuntary migrant maternal women as being exposed to trauma and violence. However, nurses expressed lack of professional practice support in integrating trauma and violence-informed care within care provision among women with involuntary migrant status. Instead, nurses drew on experiential knowledge to support compassionate care delivery. The third identified central area critical to nursing care provision was integrating language and cultural diversity.

Many nurses in this review centered care provision around a woman's cultural beliefs. Remaining open to learning new cultural understandings of maternal health, while also flexing organizational protocols to provide culturally sensitive care, were integral to most nurses' practice in this review. Many nurses in this review advocated for visually creative and ethically safe strategies to address language barriers. Ensuring the comfort of a woman when working with an interpreter and ensuring interpreters' adherence to confidentiality were responsibilities nurses took when providing care.

Implications for practice

This review found four implications to enhance nursing practice and the policies that shape care provision. First, migrant status is critical to understand as a health determinant shaping women's health. Nursing education programs should integrate how migrant policies impact the health of involuntary migrant maternal women. This will teach nurses how to assess migrant status, as well as help them understand how the status may impact the way in which women access health services.

The findings of the review also highlight the need for ongoing professional development centered around assessing migrant status, and trauma and violence-informed education initiatives targeting involuntary migrant maternal women's contexts. Aims of these initiatives include promoting disclosure of trauma and violence exposure to prevent women's potential disengagement with health care systems.

A third implication for practice addresses the need to create innovative strategies to overcome language barriers. Exploring strategies that support nursing practice across acute and community health care contexts in the absence of interpreters is recommended. Policies should address the risks of using family members or Google Translate as communication tools.

Lastly, ensuring that clinical care pathways address health issues among involuntary migrant maternal women is recommended to ensure safe provision of care. Timely maternal health follow-up and close monitoring are advised due to minimal antenatal care resulting from involuntary migration status and pre-migration experiences. This should involve interdisciplinary partnerships, which provide nurses with opportunities to work with professionals focused on addressing involuntary migrant maternal women's health and well-being.

EXPERIENCES OF NURSES CARING FOR INVOLUNTARY MIGRANT MATERNAL WOMEN

POPULATION
Nurses

PHENOMENA OF INTEREST
Experiences of providing care to involuntary migrant women who were pregnant and/or mothering

CONTEXT
Acute and community health care environments in both urban and rural areas

SYNTHESIZED FINDINGS

Nurses integrate cultural and linguistic diversity within practice

Nurses are sensitive to diverse health beliefs and ways of communicating health concerns and adapt their practice to support and integrate cultural sensitivities into the delivery of care.

Nurses assess for inequities resulting from forced migration on maternal women

Nurses recognize many involuntary migrant women as having a high-risk pregnancy and needing specialized care pathways to meet their complex maternal health needs.

RECOMMENDATIONS FOR PRACTICE

POLICY EDUCATION

The impact of migrant policies on the health of involuntary migrant women should be integrated into nursing education curriculum and ongoing professional development across acute and community professional practice.

(Grade A)

VIOLENCE AND TRAUMA EDUCATION AND SUPPORT

Providing nurses with ongoing education and support related to the integration of trauma and violence-informed care within practice is recommended.

(Grade A)

STRATEGIES TO OVERCOME LANGUAGE BARRIERS

Exploring innovative strategies to overcome language barriers between migrant women and nurses in acute and community health contexts when interpreter services are unavailable, or when the woman does not feel comfortable with the interpreter, is advised.

(Grade A)

CLINICAL PATHWAYS

To ensure the safe provision of care, clinical pathways should address the complexity of health issues experienced among involuntary migrant maternal women.

(Grade A)

References

1. Kassam, S., Butcher, D., Marcellus, L. Experiences of nurses caring for involuntary migrant maternal women: a qualitative systematic review. JBI Evid Synth. 2022; 20(11):2609-55.

Summary Writers

Shahin Kassam[1], Diane Butcher[2], Lenora Marcellus[1]

1 University of Victoria, School of Nursing, Victoria, British Columbia, Canada

2 Employment and Social Development Canada, Victoria, British Columbia, Canada

Acknowledgments

This Best Practice Information Sheet was developed in collaboration with the JBI and nominees of JBI Collaborating Entities.

How to cite this Best Practice Information Sheet:
Kassam, S., Butcher, D. & Marcellus, L. Best Practice Information Sheet: Experiences of nurses caring for involuntary migrant maternal women. JBI EBP Database. 2022; 24(5):1-5

JBI, Faculty of Health and Medical Sciences, The University of Adelaide SA 5006, AUSTRALIA

Email: jbi@adelaide.edu.au | https://jbi.global