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CLINICAL CONCEPTS

Creating safe relational space: Public health nurses work with mothering refugee women

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Abstract

Objective: Exploring how public health nurses (PHNs) provide community-based support to women who are refugees and mothering.

Design: A constructivist grounded theory (CGT) design was used where intersectionality as an analytical tool was applied. Varying data collection approaches including focus groups were used.

Sample: Twelve PHNs from four public health units in Western Canada participated in this study.

Results: Participants in this study described an overall process of *creating safe relational space* to address a basic social problem of establishing trust while managing structural forces. This overarching process was expressed through burning with passion, connecting while looking beyond, protecting from re-traumatization, and fostering independence. Findings reveal strategies PHNs used to enhance health equity. This study extends critical caring theory to include sociopolitical and economic influences on public health nursing practice. Consequences of these influences on the mothering refugee women population are also revealed. Implications include structural integration of trauma-and-violence-informed principles to support public health nursing practice.

Conclusions: This study adds to an emerging body of knowledge on PHNs work with complex populations. Innovative application of intersectionality is demonstrated as an effective approach to analyzing impacts of broad sociopolitical priorities on communities that are systemically marginalized.

KEYWORDS
mothers, public health nursing competencies, public health nursing practice, refugee, social justice, trauma, vulnerable populations, women's health

1 | BACKGROUND

Over the past decade, over 50 million women have been forcibly displaced from their homes worldwide (United Nations High Commissioner of Refugees [UNHCR], 2020). Many of these women are forced to leave their countries due to issues including war, persecution and/or climate crises and thereby categorized as refugees. These issues continue to exacerbate yearly shaping the exponential growth of refugees worldwide.

The Canadian context includes a history of settling over 700,000 refugees in the past 40 years (UNHCR, 2019). Public health services are one of the primary points for complex populations such as refugees to enter into the Canadian health system (Canadian Nurses Association-Canadian Medical Association, 2013). Situated within communities across Canada, public health units consist primarily of public health nurses (PHNs) who provide health and wellness services. Specific foci include implementing various health promotion programs targeting maternal-child health, and providing immunization

clinics (Government of British Columbia, 2020). All Canadian territories and provinces have variations of how PHNs function according to their own unique contexts. This study focused on PHNs working in the province of British Columbia (BC).

1.1 | Contextualizing refugee women and the PHN role

Most women migrating to Canada are of child-bearing age or already mothering (Brown-Bowers et al., 2015). Many women living with refugee statuses experience disproportionate health experiences including higher rates of interpersonal violence, and mental health concerns including postpartum depression and post-traumatic stress disorder (O'Mahony et al., 2013; Vigod et al., 2017). Impacts of these inequitable health experiences include furthered social disconnectedness, poverty, and intergenerational effects including chronic anxiety disorders and reduced capacities to create thriving livelihoods (United Nations Population Fund, 2016).

Although a small body of literature exists that addresses the PHN role in working with refugees (Leppälä et al., 2020; Rifai et al., 2018; Teng et al., 2007), minimal studies have addressed how PHNs work and support women who are mothering while also managing their refugee status.

2 | RESEARCH QUESTION

What are the processes used by PHNs in their work with women who are mothering and managing the effects of their refugee status?

3 | ETHICAL APPROVAL

This study was approved by the local health authority Research Ethics Board and the University of Victoria's Human Research Ethics Board. In March 2020, data collection was temporarily paused by the local health authority ethics review board due to the COVID-19 global pandemic. Data collection resumed in May 2020 with ethics approval to conduct remote one-on-one interviews of retired PHNs only since practicing PHNs had been seconded to public health initiatives related to COVID-19. In July 2020, ethics approval was received to remotely recruit and collect data from practicing PHNs through snowball sampling.

4 | DESIGN AND METHODS

Constructivist grounded theory (CGT) was selected as a way to address oppression and draw attention to overlooked injustices (Charmaz, 2014). Specifically, our social-justice-oriented intentions were facilitated through CGT in describing social processes where power relations often lie unnoticed (Charmaz, 2014; Glaser & Strauss, 1967). In addition, we innovatively applied intersectionality as an analytical tool to highlight the interconnected social, political and economic networks embedded within data collected (Collins, 1993; Kassam et al., 2020).

To enhance social-justice-oriented intentions embedded within CGT, intersectionality was applied as an analytical tool toward revealing structural issues and contextualizing power relations that shape data collected. While this design was a novel approach that refines intersectionality as a pragmatic and critical social theory, it also advances CGT methodology toward social justice intentions.

4.1 | Participants and recruitment

Four urban public health units located within communities where refugees were densely populated served as the study setting. PHNs practicing within these health units were invited to participate. Excluded from recruitment were PHNs who worked outside of the local health authority and PHNs without experience working with refugees. Two sampling methods were used: initial and snowball (Charmaz, 2014; Glaser & Strauss, 1967). Initial sampling involved sending an invitation to supervising managers of targeted health units. The invitation provided interested PHNs with contact information to initiate participation.

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. Two participants were recruited through snowball sampling. A total of 12 PHNs participated in this study. Ten participants were practicing PHNs, one was a public health unit manager and one PHN had retired 1 month prior to being interviewed. Participants ranged in years of experience from 4 to 25 years. All PHNs worked directly with refugee mothers in varying roles including home visitor, immunization service provider and lactation consultant. Eleven participants were Caucasian and one participant was a visible minority who described herself as a migrant woman.

4.2 | Data collection

Grounded theory approaches of concurrent data collection and analyses including coding, and constant comparison were employed (Charmaz, 2014; Glaser & Strauss, 1967). Participant data was generated by conducting one-on-one and focus group interviews at locations of participants' choices. All participants chose to be interviewed at their respective public health units. After reviewing the purpose of this study and inviting questions regarding signed written consent forms, semi-structured interviews were conducted and digitally recorded. Interview duration ranged from 45 to 90 min. All participants during in-person interviews were provided with gift cards in appreciation of their time and participation. Theoretical sampling was also employed as a data collection method unique to grounded theory.

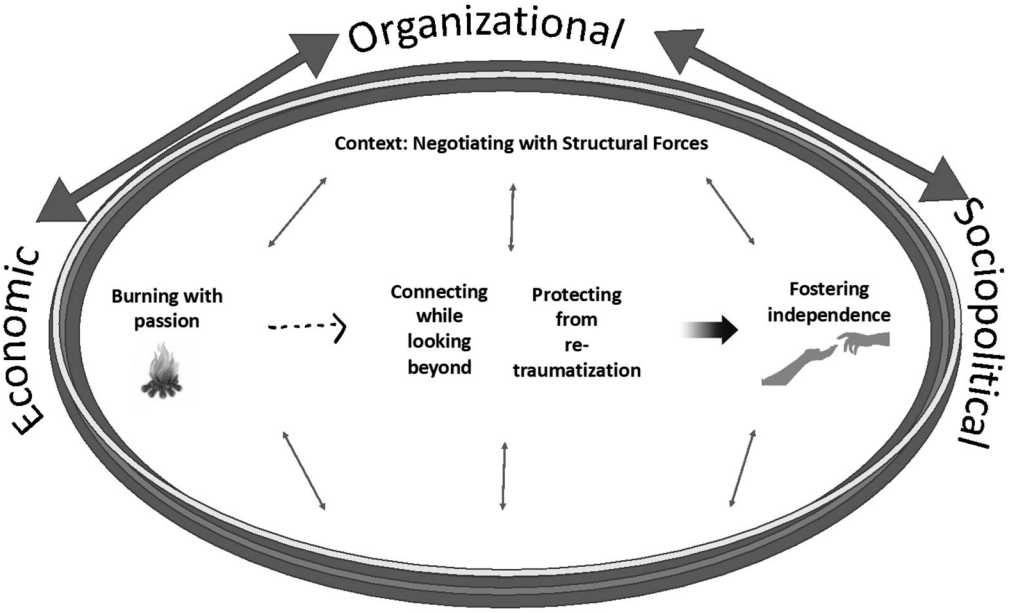

FIGURE 1 Creating safe relational space: A constructivist grounded theory of public health nurses establishing trusting relationships with mothering refugee women while managing structural forces.

4.3 | Data analysis

Digital recordings were transcribed and three coding techniques were applied in this study: initial, focused and axial. Constant comparison of data occurred with focus on finding similarities and differences in participant stories (Charmaz, 2014; Glaser & Strauss, 1967). Intersectionality as an analytic tool informed critiquing the data toward formulating categories that appreciated structural and contextual forces and power relations (Kassam et al., 2020). Specifically, intersectionality guided focus on highlighting stories that addressed the interplay of gender, race and/or socioeconomic class and the broader issues that impacted these narratives. Through these inductive processes, a basic social process emerged as a central phenomenon that was pliable yet resilient and remained visible within all constructed categories (Strauss & Corbin, 1990).

5 | RESULTS

Intentions of ground theory include revealing basic social problems occurring within data collected. The basic social problem affecting PHNs in this study was *establishing trusting relationships with mothering refugee women while managing structural forces*. PHNs engaged with this problem through a basic social process of creating safe relational space. As visually displayed in Figure 1, a concentric oval surrounds all processes PHNs employed. These processes are located at the center of the oval and depict the temporal nature of a PHNs relationship with a mothering refugee woman. PHNs entered into their relationships with women through processes of burning with passion.

PHNs then moved into two intersecting activities: connecting while looking beyond, and protecting from re-traumatization. PHNs then entered into the final processes of fostering independence. Marking the transitioning of refugee women into mainstream standards of primary health care, fostering independence also symbolized PHNs exiting from their relationships with mothering refugee women. All processes occurred within a context of negotiating with structural forces. Intersections within Figure 1 are symbolized by arrows as well as overlapping circles. Table 1 further describes the meaning of these intersections.

5.1 | Burning with passion

Participants 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.

5.1.1 | Reflecting on self

Considering their own identities, PHNs articulated intersections of gender, race, motherhood and professional identity as fueling their work with mothering refugee women. One 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

TABLE 1 Legend of interacting intersections occurring within visual diagram

Symbol	Meaning
Concentric Oval	Represents the structural forces that contextually shape the processes located within the oval
Organizational, Sociopolitical, Economic	Represents the specific structural forces revealed within the data
Arrows located in outer circle	Represents the interaction of structural forces
Arrows located in inner circle	Represents the contextual interaction of the structural forces with the processes within the oval
Broken Arrow	Represents PHN concern over fragmented referral systems leading to refugee women's disconnection from public health nursing services
Faded Arrow	Represents moral ambiguity and hesitancy PHNs experienced with needing to move women toward standardized care
Overlapping circles	Represents the porous nature of PHN processes thus demonstrating situational complexity of PHN work

> 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 raised racialization as exacerbating settlement challenges among maternal refugee women.

5.1.2 | Working toward social justice

Many participants spoke about working with mothering refugee women because of their passion for complex populations. Working within values of social justice, 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 with navigating our health care and adjusting to life in Canada.

This PHN articulated the inequitable 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. Fueled by their passion and drive to fulfill social justice values, PHNs entered into their work with refugee mothers through two interconnected processes: connecting while looking beyond and protecting from re-traumatization.

5.2 | Connecting while looking beyond

PHNs established connections with women through considering the interconnections between women's migration journeys, culture, and gender. Strategies used by PHNs within this process included building trust and engaging with complexity.

5.2.1 | Building trust

Considering the turbulent migration journeys where risk of traumatic and violent experiences is high among women, PHNs described developing trust as essential to connecting with refugee mothers. For example, one PHN pointed to women's migration journeys as a key influential factor to trusting and/or mistrusting 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 trust-mistrust dynamic among maternal refugee women, PHNs emphasized building relationships as central to dealing 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 already trusted.

5.2.2 | Engaging with complexity

Many PHNs described challenges faced by women as being embedded within the intersections of social locations such as gender and culture. One participant described isolation as a challenge shaped by these the interplay of these locations:

> So there are so many intersections in being a refugee woman versus refugee men. And most times, 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 husband's support. So that's another intersection right there. So…when we talk about refugees…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 shape social integration but also encouraged avoiding generalization of refugee women. Being flexible in accommodating mothering refugee women's needs was a strategy PHNs used to engage with such complexity.

5.3 | Protecting from re-traumatization

The experience of forced migration was described by PHNs as intense disruption, trauma, and violence. Strategies used to protect mothering refugee women from further harm included: realizing the triggers, and walking hand-in-hand.

5.3.1 | 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…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. Loss of power that comes with experiencing physical and sexual violence was reflected upon by some PHNs. To foster empowerment among refugee women toward healing from such trauma, PHNs channeled changes associated with motherhood. The capacity to breastfeed and provide infant nutrition was one such change utilized to overcome trauma-related powerlessness.

5.3.2 | 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. For example, one PHN articulated navigating women within a system fraught with barriers that impede access to health and social services:

> 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 and how to navigate the health system to advocate the needs of refugee mothers such as this one.

5.4 | Fostering independence

In moving their relationships with mothering refugee women forward, PHNs shifted into fostering independence toward standard stream integration. Key strategies included focusing on strengths and bridging to the standard.

5.4.1 | Focusing on strengths

Using a strength-based approach, mothering refugee women's knowledge and resilience were described as stemming from their articulations of faith, culture, and desires 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…I have two families that 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 caregiving abilities are just like, some of them are just phenomenal, just building on that, those strengths are huge.

This PHN voiced how she informed her practice through assuming refugee women had endured experiences of trauma and violence. She also advised focusing on strengths as a strategy to foster healing and empowerment.

5.4.2 | Bridging to the standard

Participants also described connecting mothering refugee women to standardized practices. PHNs identified their role as pivotal to promoting equality and adapting to mainstream health services. Ensuring refugee mothers were connected to the community was described by one PHN as demonstration of bridging refugee women to standardized practices:

> 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.

5.5 | Negotiating structural forces

This process influenced how PHNs operationalized creating safe relational space. Structural forces were described by participants as broad institutional networks that influenced their practice. Strategies PHNs used to negotiate structural forces were: palpating the changes, and managing system priorities.

5.5.1 | Palpating the changes

This strategy outlines how PHNs kept fingers on the pulse of changes within their role as well as within the communities they work within over time. PHNs described how system changes that led to their diminished community presence impacted mothering refugee women's connection to public health services over time. One PHN articulated the juxtaposition between their minimal community presence and a rapidly changing demographic where large groups of refugees were settling:

> 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 I felt like they knew who I was and I was welcome in the home… And I find with the refugee families…well 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…

PHNs described decreased interactions with mothering refugee women despite increased maternal refugee populations in their communities. Attributing this to "broken" referral pathways to public health units, PHNs described word-of-mouth as the best way for refugee women to connect with public health unit services.

5.5.2 | 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…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.

6 | DISCUSSION

This study builds on current knowledge in three key ways: to extend critical caring nursing theory (Falk-Rafael, 2005), to highlight the consequences of an eroding PHN discipline on a complex population, and to facilitate structural integration of trauma-and-violence informed principles to foster supporting PHNs in care provision. First, this study supports and extends critical caring theory toward addressing navigating multiple structural forces. 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. Hill (2017) extends Falk-Rafael's (2005) critical caring theory through including "navigating organizational complexity" to appreciate how PHNs manage organizational change toward ensuring healthy outcomes. This study further builds on this extension through magnifying how PHNs integrate the effects of broad sociopolitical, economic and organizational structures on health outcomes among complex populations.

Secondly, consequences of ever-changing funding decisions revealed within this study included PHNs working within barriers of limited resources and increased workloads. These consequences relate to the invisibility of public health skillsets rendered by the erosion of population-based activities, decades of reform, lack of public health funding, and integration of public health with primary health care (Cusack et al., 2017; Marcellus & Shahram, 2017). This study 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, and being disconnected from public health service referral pathways. With refugee women experiencing barriers to accessing healthcare services, especially through acute care sectors such as emergency departments (Guruge et al., 2018; Racine & Lu, 2015), public health

nursing offers a platform for a coordinated and culturally safe entrance into healthcare. Instead, women are left to self-navigate barriers to healthcare services thereby hindering integration into networks of social and healthcare systems.

Lastly, this study found PHNs relying on minimal guidance to ensure avoidance of re-traumatization among women. This finding is supported in the literature where many nurses are challenged by integrating trauma-and-violence informed care principles into daily practice (Hall et al., 2016; Muskett, 2014). More recently, trauma-and-violence informed care has been framed as an organizational endeavor rather than a simple delivery of theory that is expected to rest on solely the shoulders of those delivering care (Marcellus, 2014; Stokes et al., 2017). This study builds on this literature and finds PHNs as pivotal to engaging with trauma-and-violence care among mothering refugee women who are exposed to traumatic events across the forced migration journey. However, this study also finds the need for further structural support to foster such engagement.

Implications to public health nursing within this study include the need for critically analyzing structural integration of trauma-and-violence informed principles among organizational policies. This includes on-going educational opportunities to explicitly engage with trauma-and-violence principles. It also includes integrating forced migration as a health determinant within assessment tools to support PHN practice. Secondly, analysis of referral pathways to public health services is advised. This includes understanding how coordination of migrant settlement services and public health services can be enhanced. Additionally, this study draws attention to the value of harnessing public health nursing roles across acute and community care sectors toward more coordinated efforts in providing safer care for complex populations such as mothering refugee women.

6.1 | Limitations

Lack of diversity in participant demographics was a limitation of this study where most participants were homogenous in gender, race and migrant status. Despite attempts to recruit PHNs from rural community health centers, participants voicing interest in this study were primarily from urban settings which limited understanding of rural experiences.

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 endeavors. Organizational priorities impeded efforts to recruit PHNs even after suspensions were lifted due to added epidemiology-focused roles related to varying pandemic responses across health authorities.

7 | CONCLUSION

This CGT contributes to a small body of knowledge targeted at understanding PHNs unique competencies and disciplinary contributions in engaging with mothering refugee women. 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. The novel application of intersectionality within this study brings attention to broad economic and sociopolitical influences that directly impact systemically marginalized populations such as mothering refugee women. As a result, this theory has generated implications involving organizational integration of trauma-and-violence informed principles that would support ongoing educational opportunities for PHNs. Such integration would also support PHNs in enhancing practice toward explicit engagement with forced migration as a health determinant. These organizational implications hold potential in enhancing health through promoting equity and advocacy which are central competencies unique to the PHN discipline (Cusack et al., 2017). This study thus increases the visibility and importance of PHN work with the complex population of women who are mothering and living with refugee statuses.

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CONFLICT OF INTEREST

We declare that there is no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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