Experiences of nurses caring for involuntary migrant maternal women: a qualitative systematic review

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ABSTRACT

Objective: The objective of this review was to identify, critically appraise, and synthesize qualitative evidence on the experiences of nurses providing care within various health care delivery environments to involuntary migrant women who are experiencing pregnancy, birth, or post-birth.

Introduction: Nurses are central to providing care to populations experiencing inequities. These populations include forcibly displaced pregnant and/or mothering women who have migrated involuntarily. Most of these women 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: This review considered qualitative, peer-reviewed studies published in academic journals. Studies and study abstracts that examined nurses' experiences of providing care to involuntary migrant maternal women were included. Women could be pregnant and/or mothering. All settings in which nurses practice were considered.

Methods: Information sources that were systematically searched for this review included CINAHL (EBSCO), PsycINFO (EBSCO), MEDLINE (EBSCO), PubMed (NLM), Web of Science, and Google Scholar. A gray literature search in Google was also developed. Studies published in English from 2000 onward were considered. 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 involuntary migrant maternal women. An intersectionality lens was applied within all review methods. Study selection was conducted by two reviewers who screened titles and abstracts that aligned with the inclusion criteria. The review followed the JBI approach for critical appraisal, data extraction, and data synthesis.

Results: Twenty-three qualitative studies were included in this review. Qualitative methodologies within these studies included case study, ethnography, interpretive descriptive, and grounded theory. Nine studies considered the sex of participating nurses, and three studies considered participant history of migration. A total of 115 findings were pooled into four categories and aggregated into the following two synthesized findings: i) Nurses integrate cultural and linguistic diversity within practice; and ii) Nurses assess for inequities resulting from forced migration on maternal women. Study quality was rated as moderate on ConQual scoring, with dependability rated as moderate and credibility rated as high.

Conclusions: Key implications are made within nursing education programming, nursing practice, and policy analysis. In the realm of nursing education, integration of migrant status as a health determinant will enhance nurses' skills in assessing migrant status and understanding how varying statuses contribute to barriers among involuntary migrant women accessing health services. Providing ongoing education to nurses centered on trauma and violence-informed practice is recommended. With regard to nursing practice, review findings revealed the need for creative solutions to overcome language barriers. Innovative approaches for nurses working across language barriers in acute and community health contexts when interpreter services are not available need further exploration and protocol integration. Examination of clinical care pathways is needed for inclusion of involuntary migrant women, and exploring assessment strategies targeting how migrant status contributes to limited health

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service accessibility. For policy, organizations need to build policies that promote examination of migrant status and its health impacts among involuntary migrant maternal women exposed to migration-related trauma and violence to support nurses in their care provision.

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Summary of Findings

Experiences of nurses caring for involuntary migrant maternal women					
Bibliography: 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):2609–2655.					
Synthesized finding	**Type of research**	**Dependability**	**Credibility**	**ConQual score**	**Comments**
Synthesized finding 1: Nurses integrate cultural and linguistic diversity within practice Nurses' experiences demonstrated the need for 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 delivering culturally sensitive care. Addressing linguistic diversity within nurses' experiences included careful use of interpreter services and exploring approaches to universal demonstration of care.	Qualitative	Moderate (Downgrade one level)	High	Moderate (Downgrade one level)	Dependability: Downgraded one level due to 12 out of 23 studies scoring 3 for the questions relating to location of the researcher culturally or theoretically and acknowledging researcher influence on the research. Credibility: All findings were found unequivocal within this review.
Synthesized finding 2: Nurses assess for inequities resulting from forced migration on maternal women Nurses' experiences of caring involved managing the effects of migrant policies that generated inequitable access to health and social supports among involuntary migrant maternal women. Mitigation of such inequities included addressing health determinants such as social isolation and migrant status. Nurses' experiences of care demonstrated unique skillsets to assess pre-migration experiences and bridge women to networks of social and health support.	Qualitative	Moderate (Downgrade one level)	High	Moderate (Downgrade one level)	Dependability: Downgraded one level due to 12 out of 23 studies scoring 3 for the questions relating to location of the researcher culturally or theoretically and acknowledging researcher influence on the research. Credibility: All findings were found unequivocal within this review.

Introduction

Global fragility has created multiple humanitarian crises, including individuals and families being forced to leave their homes due to war, persecution, and climate change. In the previous 10 years, 100 million people have been forced to involuntarily migrate away from their homes worldwide.[1] Drawing on the United Nations High Commissioner for Refugees and the United Nations International Organization of Migration, populations that are forcibly displaced from their home countries due to political and socioeconomic issues such as war, climate change and/or persecution are defined as involuntary migrants.[1,2] Those who migrate involuntarily are grouped into varying legal categorizations depending on the country they are being settled within. Such categories include "refugee," "internally displaced," and/or "stateless," depending on the settlement country policies.[1] While these categories can be used interchangeably within media and migrant discourse, each category is tied to a specific country's network of intersecting policies, which dictate and impact health and well-being.[1,2]

Half of the global forcibly displaced population consists of women and girls, many of whom are of child-bearing age, pregnant, or mothering.[1] The health and well-being of women who are experiencing pregnancy, birth, or post-birth is defined by the World Health Organization (WHO) as "maternal health."[3] This definition informs this review in conceptualizing "maternal women" as women experiencing maternal health. As per WHO guidelines, post-birth care is conceptualized as care provided by nurses for six weeks after a woman has experienced childbirth and has transitioned into mothering processes.[3]

The concept of mothering within this review is defined through the seminal works of Chris Bobel as a social construction of women who birth and move through processes of child-rearing within their unique sociocultural contexts.[4] The term "involuntary migrant maternal women" is therefore a focus within this review and used throughout to specifically reflect women experiencing forcibly displaced migrant status as well as pregnancy, birth, or post-birth and mothering. The focus of this review was on women only, which was driven by the participants in the included studies.

The state of a woman's maternal health is inextricably linked to her migration journey and migration status. 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. Involuntary migrant maternal women experience higher rates of HIV, mortality, cesarean delivery, 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. Populations forcibly displaced are disproportionately disadvantaged socioeconomically than those migrating voluntarily, and often live in impoverished conditions.[7,8] Care provided to involuntary migrant maternal women is therefore critical to ensure engagement with complex health issues and enhancement of health trajectories.

Nurses are well-positioned across varying health care delivery environments to provide the necessary care to this population of maternal women. Recognized as pivotal members within multidisciplinary teams, nurses have the potential to integrate broader health determinants within their care provision.[9] Within this review, nurses were defined as individuals educated within nursing programs and authorized by their country's regulatory practice organizations to provide care.[9] Nursing care provision was defined by drawing on International Council of 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 health care contexts, ranging from acute and chronic care to primary and community care settings.[9] This definition excludes disciplines that do not align with this ICN definition, such as midwives, social workers, and doulas. Although, in many countries, some care providers function as nurse-midwives where midwifery education and a subsequent midwifery role has been assumed, the midwifery discipline differs from nursing in its philosophy and scope of practice.[10]

Within current literature, researchers have explored health care professional and nursing experiences of working with involuntary migrant maternal women.[11] Within several global reports, nurses have been identified as part of interdisciplinary teams working collaboratively toward addressing multilayered health issues.[12,13] In addition, studies have also been conducted exploring barriers to care

provision among nurses. These include cultural and linguistic barriers, where lack of understanding languages spoken and traditional practices were encountered by nurses.[14,15] Understanding nurse experiences has been ascertained as critical to identifying barriers embedded within structural forces, such as policies and practice directives.[16] Multiple studies have been conducted highlighting adverse health outcomes and barriers faced by populations forcibly displaced. Researchers have explored nurses' experiences of caring for involuntary migrant maternal women within a wide variety of disciplines, including population and public health[15]; nursing[17]; women's, families', and children's health[18]; and cultural anthropology.[19] A lack of systematic reviews exploring nurse experiences of caring for involuntary migrant maternal women was identified 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 involuntary migrant maternal women across health care delivery environments.

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 again in September 2021 revealing systematic reviews focused on experiences of care from migrant women's and community-based doulas' perspectives. However, none focused on nurses' care provision experiences, and no current or in-progress systematic reviews on the topic of nurses' experiences of caring for involuntary migrant women were identified.

The overarching review objective was to identify and describe the experiences of nurses providing care to involuntary migrant maternal women within various health care delivery environments.

Review question

What are the experiences of nurses providing care within various health care delivery environments to involuntary migrant women who are pregnant and/or mothering?

Inclusion criteria

Participants

This review considered studies that included nurses involved in caring for involuntary migrant pregnant and/or mothering 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 women who involuntarily migrated and were pregnant and/or mothering. Studies that revealed findings from interdisciplinary groups that included nurses were also included in this review when data were explicitly attributed to nurses. 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 nurses' experiences of providing care to involuntary migrant women who were pregnant and/or mothering. 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, which 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 involuntary migrant 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 JBI methodology for systematic reviews of qualitative evidence.[20] This review was conducted in accordance with an a priori protocol registered in

PROSPERO (CRD42019137922).[21] The title of this review deviated from the protocol to provide clarity on the focus of forced migration status among maternal women being cared for by nurses.

Search strategy

The search strategy aimed to locate published primary studies and gray literature. A three-step search strategy was utilized in this review. First, an initial limited search of CINAHL (EBSCO), PsycINFO (EBSCO), and MEDLINE (EBSCO) 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 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 rerun in January 2021 using the same search strategy to ensure up-to-date identification of literature. This revealed an additional two studies that were included in the review. The full search strategies are provided in Appendix I. The third search involved screening the reference lists of all studies selected for critical appraisal for additional studies.

Search terms were devised in consultation with the first reviewer's university librarian. This consultation led to including the terms "health care providers" and "health care workers" in the search strategy for some databases to capture nurses working within interdisciplinary teams. Due to the prevalence of nurses working within interdisciplinary teams, experiences of nurses made explicit by study authors were included despite the interdisciplinary context. This inclusion of terms was a deviation from the protocol.

Only studies published in English were included due to the unavailability of professional translation services. Studies published from January 2000 to January 2021 were included, as this review was not a historical analysis; preliminary searches revealed sources were published from 2002 onward.

The databases that were searched included CINAHL (EBSCO), PsycINFO (EBSCO), MEDLINE (EBSCO), PubMed (NLM), Web of Science including Social Science Citation Index, and Google Scholar. The use of gray literature in this review was to complement and support findings. A gray literature search strategy was devised using Google, and targeted specific global nursing organization websites that contained position statements, reports, and press information (see Appendix I). Sources were located through keyword searches based on our database search strategies. No unpublished studies were found in the gray literature search.

Study selection

Following the search, all identified citations were collated and uploaded into EndNote v.X9.2 (Clarivate Analytics, PA, USA) and Covidence (Veritas Health Innovation, Melbourne, Australia), and duplicates were removed. Following a pilot test, titles and abstracts were screened by two independent reviewers (SK, DB) for assessment against the inclusion criteria for the review. Potentially relevant studies were retrieved in full and their citation details imported into the JBI System for the Unified Management, Assessment and Review of Information (JBI SUMARI; JBI, Adelaide, Australia).[22] Full-text studies that did not meet the inclusion criteria were excluded, and reasons for their exclusion are provided in Appendix II. Any disagreements that arose between reviewers were resolved through discussion.

Assessment of methodological quality

Eligible studies were critically appraised by two independent reviewers (SK and DB) for methodological quality using the standard JBI critical appraisal checklist for qualitative research.[23] Any disagreements that arose between the reviewers were resolved through discussion. A third reviewer was available to assist with disagreements, but was not required.

After both independent reviewers completed the study appraisal, the reviewers discussed each article and assigned scores. Differences in scores were reviewed by examining how each reviewer interpreted the appraisal tool question. The JBI methodology for systematic reviews of qualitative evidence was consulted for clarification.[20] Discussion on the philosophical approach of each reviewer being situated within critical feminism also took place, which informed application of inclusion and exclusion criteria. Most studies did not address theoretical position or researcher influence on research. Fundamental criteria for excluding studies on the basis of methodological quality included adequate representation of participant voice. Adequate representation of participant voice was approached within studies that pooled nurses' experiences with other multidisciplinary team members through identifying and extracting data that were clearly stated by study authors as directly derived from participants identified as nurses.

Data extraction

Qualitative data were extracted from studies included in the review by two independent reviewers (SK and DB) using an adapted JBI data extraction tool (see Appendix III).[20] The data extracted included specific details about the following characteristics:

- methodology used;
- participants (number of nurses included, gender, migration history, and race/ethnicity);
- phenomena of interest;
- characteristics of involuntary migrants;
- health care setting and nursing role;
- country in which study was conducted.

Extracting terms used for "nurse," "immigrant," and "refugee" was omitted, and is a deviation from the protocol, as this would be more appropriate to conduct within a scoping review. Instead, roles of nurses as described in the included studies were extracted to contextually expand participants' experiences. Additionally, participant characteristics, including gender, migration history, and race/ethnicity, were extracted to expand on participant context. The number of nurses included in participant study samples was extracted due to broader search terms needed within certain databases (see Appendix I). This captured nurses working within interdisciplinary teams and the need to identify how many nurses from these teams were included.

Characteristics of involuntary migrant maternal women were extracted to identify migrant discourse within studies, which informed analysis of this review. Findings, and their illustrations, 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 quote from a study participant. 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.[24] All findings were found to be unequivocal within this review.

As this review is 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. Data extraction was guided by intersectionality as a theoretical lens to highlight social variables, including, but not limited to, gender, race, and migrant status. Situated within critical feminist theories, intersectionality guided thinking within data extraction toward identification of variables that interconnect to shape nurses' experiences of caring for involuntary migrant maternal women.[25] 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.[24,26] Meta-aggregation is the process of generating a synthesized finding, which is an interpretive description of a grouping of categorized findings. 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. Theoretical guidance informing this process was drawn from Patricia Hill Collins' interpretations of intersectionality, which illuminates what is happening within social problems, focusing on under-represented complexities such as gender, race, and migrant status, and how they contribute to oppression.[25] 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. With this review being part a doctoral dissertation for SK, the data synthesis process of grouping and categorizing findings was completed

by SK and discussed with DB. Numerous discussions regarding analytical steps occurred between them throughout the data extraction and synthesis processes via email and videoconferencing. A journal was also kept by SK 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.[26] The Summary of Findings includes the major elements of the review and details how the ConQual score was developed. Included in the table are the title, participants, phenomena of interest, and context for this specific review. 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 the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram (Figure 1),[27] the search strategy conducted in January 2020 across selected databases identified 4079 studies. 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 4081. After titles and abstracts were screened for eligibility and duplicates removed, 4021 were excluded for being irrelevant to the phenomena of interest and not meeting inclusion criteria. The 60 remaining articles were imported from EndNote to Covidence and screened for inclusion. Twenty-four studies did not meet the inclusion criteria and were removed.

Full-texts of the remaining 36 articles were screened by the primary and secondary reviewers. Due to population, phenomena of interest, and study designs not meeting inclusion criteria, 13 studies were excluded. See Appendix II for further exclusion details. The remaining 23 studies were imported into JBI SUMARI for critical appraisal. Prior to appraisal, the reference lists of these studies 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.[23] No further studies were excluded.

Gray literature used within this review did not include unpublished studies. Using gray literature to support findings within an area where minimal research has been conducted is supported by Benzies *et al*.[28] The use of gray literature as a complementary and supportive source is also advised within JBI and systematic review guidance.[20] Therefore, unpublished gray literature was applied to reinforce review findings and included WHO press information and ICN position statements.[12,29-32]

Methodological quality

Based on the results of the JBI critical appraisal checklist for qualitative research,[23] the included studies were deemed moderate by both the primary and secondary reviewers. Each study was scored on 10 questions: 12 studies scored 8 "Yes" responses,[14,15,18,19,33-40] 7 studies scored 9 "Yes" responses,[17,41-46] and 4 studies scored 10 "Yes" responses.[11,47-49] The primary and secondary reviewers discussed each study to resolve any discrepancies. Discussing standards for inclusion from the theoretical approach of intersectionality was central to these resolutions.

In an effort to avoid premature exclusion of studies,[50] the reviewers erred on the side of inclusion by avoiding narrow conceptions of appraisal. This entailed not specifying any particular appraisal questions as essential for inclusion for this review. However, adequate participant voice was imperative to guide decision-making for inclusion and quality to ensure nurses' experiences were captured. Methodological quality scoring was also impacted by epistemological differences in studies included where an objectivist approach to inquiry seemed to be assumed. Objectivism guides researchers toward assuming non-influential effects on the research and supports generation of knowledge without highlighting the values of the researcher.[51]

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? The primary and secondary reviewers discussed whether to include studies not meeting Q6 or Q7 a priori. Reasons for some researchers not locating themselves within their inquiries or addressing their influence on their

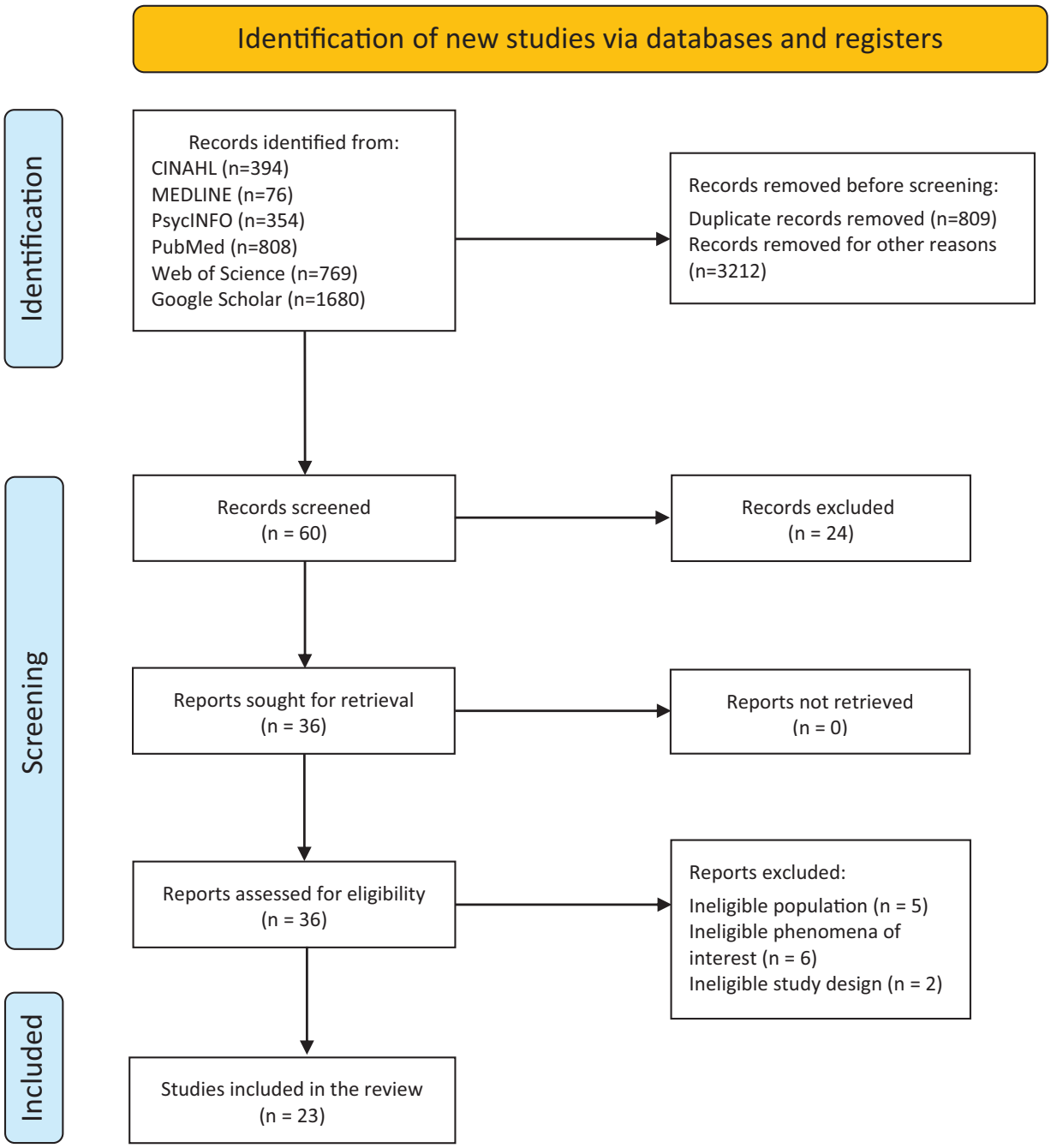

Figure 1: Search results and study selection and inclusion process[27]

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 studies that did not meet the Q6 and Q7 criteria questions. This decision aligned with the reviewers' intersectionality 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 of eligible qualitative 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[33]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Ganann *et al.*[17]	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Jean-Baptiste *et al.*[14]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Kurth *et al.*[15]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Kynoe *et al.*[46]	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Leppälä *et al.*[49]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Lyberg *et al.*[41]	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Lyons *et al.*[38]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Ng & Newbold[34]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Nithianandan *et al.*[44]	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Origlia Ikhilor *et al.*[47]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Peláez *et al.*[11]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Reynolds & White[39]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Rifai *et al.*[36]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Riggs *et al.*[18]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Sarker *et al.*[40]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Seo[19]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Skoog *et al.*[37]	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.*[43]	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Winn *et al.*[48]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Yelland *et al.*[45]	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 = Is there congruity between the research methodology and the interpretation of results?
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, 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

All studies were approached using qualitative methods. However, one study was a mixed methods inquiry,[15] and six studies provided minimal details on which qualitative approach was assumed.[18,39,40,44,45,49] The remainder of the studies in this review were described as using qualitative hermeneutic,[46] naturalistic descriptive,[42] exploratory,[14,33,34,47] interpretive descriptive,[17,48] explanatory,[35] descriptive,[43] inductive,[36,37] ethnography,[19] both descriptive and exploratory,[41] grounded theory,[38] and case study.[11] While all studies included understanding nurses' experiences as part of their phenomena of interests, five studies focused explicitly on nurses.[33,36,37,43,46]

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 six studies did not identify the number of nurses included within their multidisciplinary samples.[17,19,38-40,45] Nine studies clearly articulated the sex of their participants who were nurses as being female.[15,34,35,37,41,42,47-49] Three studies briefly mentioned the race and/or ethnicity of their participants[14,35,44] and

three studies alluded to their participants' migration histories.[17,33,35]

Results of analyzing geographical distribution of the reviewed studies indicated most studies taking place in Canada[11,17,34,35,48] and Australia.[18,43-45] Several took place within varying parts of Europe, including Finland,[42,49] the United Kingdom,[33,39] Switzerland,[15,47] Sweden,[36,37] Ireland,[38] and Norway.[41,46] One study was conducted in Bangladesh,[40] one was conducted in Thailand,[19] and one was completed in the United States.[14] Most studies took place within community health clinical settings.[14,15,17,33-37,39,42,44,48,49] Four of these settings were specialized to target involuntary migrant populations.[35,39,44,48] Other study settings included hospitals,[11,19,38,46] a densely populated humanitarian settlement site (community of refugee camps),[40] and a university.[41] Four studies did not provide specific study setting details.[18,43,45,47]

A broad range of nursing roles were described across the 23 studies appraised within this review. These included antenatal nurse,[19] psychiatric nurse,[42] family planning nurse,[42] maternity nurse,[42] maternal and child health nurse,[18,43-45] maternity care professional,[49] chronic disease nurse,[48] nursing-midwifery team (nurses working alongside midwives),[15] public health nurse,[35,36,41,49] registered nurse,[35,49] registered nurse with specialist training,[36] specially trained in management of prenatal and postnatal care for women,[41] certified nurse specialist,[46] obstetric nurse,[19] child health services nurse,[37] early childhood nurse,[45] practical nurse,[35] delivery nurse,[19] labor and delivery nurse,[48] nurse,[11,14,39,40,46,47] auxiliary nurse,[38] nurse practitioner,[34] nurse manager,[11] perinatal mental health nurse,[44] postpartum and neonatal care nurse,[19] and neonatal intensive care unit nurse.[46] Three studies, all conducted in Australia, identified refugee health nurses[18,44,45] who specifically cared for involuntary migrants. However, many studies in this review pooled nurses into general terms of maternity care professional,[49] health professional,[11,34,39,45,47] service/health care provider,[17,40,45,48] home visitor,[14] and health visitor.[33]

Studies included in this review characterized involuntary migrants predominantly as having varying migrant statuses. These included categories of refugee,[11,17-19,33,40,42-45,47,48] quota refugee,[49] asylum seeker,[15,17,33,37-39,42-44,47,49] immigrant,[11,14,17,34-37,41,42,46] humanitarian migrant,[18,43,45,49] undocumented immigrant,[11,14] undocumented migrant,[19] non-citizen,[19] non-citizen other,[19] stateless people,[19] and newcomer.[17,35,49] One study used the term Forcibly Displaced Myanmar Nationals as coined by the Bangladesh government to indicate non-citizenship status of Rohingya refugees.[40]

Having low literacy skills,[11,14,15,17-19,34-36,38,39,41,43-49] and being a cultural and ethnic minority[11,17-19,33-36,38,41,42,44-46,48] were also characteristics used to described involuntary migrants. Involuntary migrants were also described as having socioeconomic issues,[11,14,19,33,40,41,45] which included living in poverty[11,19,33,40,41,45] and living in precarious housing developments.[14,19,40,45] Characteristics of involuntary migrant women also included having experienced trauma, loss, and violence within contexts of war and persecution.[11,15,33,39-41,43-45,48] Five studies mentioned exposure to gender-based violence.[15,33,39,40,45,48] Two studies described the dependency of involuntary migrant maternal women on their spouses.[35,36] Brief descriptions of involuntary migrant maternal women experiencing racism and discrimination were mentioned in four studies.[11,33,38,43] One study's findings included descriptions of involuntary migrant maternal women's strengths where these women were viewed as ready to learn and transition into mothering in a new country despite facing hardships of forced displacement.[19] Other descriptors of involuntary migrant maternal women within this review included experiencing isolation,[19,35,36,39] having low education levels,[41,42,48] and experiencing fear and uncertainty related to uncertain futures.[15] 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 involuntary migrant maternal women. Most studies within this review included nurses within samples of interdisciplinary teams. The number of nurses who participated within these study samples were thus explicated within these studies.[11,14,15,18,33-37,41-44,46-49] Six studies did not explicate the number of nurses involved in their studies and pooled them into multidisciplinary group participant samples.[17,19,38-40,45] 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 categories occurred through considering similarities in meaning across all 115 findings. This process was grounded within the critical theoretical assumptions of intersectionality. As a result, aggregation was informed and association between findings and categories were guided toward highlighting intersecting social variables within nurses' experiences of caring for involuntary migrant maternal women. This meta-synthesis process generated two synthesized findings: i) Nurses integrate cultural and linguistic diversity within practice; and ii) Nurses assess for inequities resulting from forced migration on maternal women. Appendix V presents a meta-aggregation of the four categories with their associated findings. A complete list of study findings and illustrations is presented in Appendix VI. 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 summarized, followed by the associated categories and explanations.

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

This synthesized finding was constructed through aggregation of two categories supported by 64 unequivocal findings (see Appendix V). This synthesis reflects the need for culturally sensitive care through understanding the role of family members within women's health experiences. In being sensitive to diverse ways in which health issues are communicated among varying cultures, nurses increased their understanding of post-traumatic stress and pre-migration trauma and violence affecting the health of involuntary migrant maternal women. Communication through interpreters was described as situationally beneficial within nursing care experiences. However, this synthesis draws attention to limitations in interpretation service use and ethical considerations to integrate into nursing care practice. Further explanation of each category is described below.

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 involuntary migrant women. Many nurses were sensitive to ensuring involuntary migrant maternal women felt they were cared for despite having ethnic and cultural differences.[11,19,42,43] While some nurses recognized the presence of essentialist prejudices within nursing care delivery,[11,37] many nurses described employing cultural sensitivity through looking beyond differences and listening.[17,33,37,41,43] In addition to recognizing differences in cultural traditions, nurses also expressed a desire to understand how culture affected women's maternal care practices. Centering care delivery around a woman's cultural preferences was described by many nurses as an approach to integrating cultural awareness. This occurred by adapting care delivery protocols and policies to support cultural practices of involuntary migrant maternal 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,*[43(p.3392)]

When caring for women, many nurses described prioritizing the 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.[38] Many nurses described being open to learning new meanings of social practices to facilitate supportive relationships with involuntary migrant maternal women.[17,35,41,42,45] Being open to new meaning promoted dialogue around issues women were not accustomed to speaking about.

Many nurses described how involuntary migrant maternal women communicated mental health concerns as feelings rather than as clinical diagnoses of depression or anxiety. Additionally, some nurses described how some women avoided mental health

discussions for fear of being labeled as "crazy"[35] for not feeling happiness during joyous events such as childbirth. Screening tools such as the Edinburgh Postnatal Depression Scale were perceived as inadequate for addressing diverse cultural conceptualizations of mental health.[45] Instead, many nurses described learning culturally appropriate words related to mental health through centering care around women's dialogue.[43,45] 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 stress and experiences of pre-migration trauma that impacted coping during pregnancies, antenatal appointments, and physical examinations.[11,41,43,44]

In providing care, some nurses acknowledged sociocultural influences, such as family dynamics, as shaping involuntary migrant maternal women's traditional practices.[44] Other nurses described how family members, such as mothers-in-law or husbands, were sources of health information for women.[37] Fully understanding all nuances of particular cultures was voiced as being impractical.[33] However, many nurses described focusing care provision on heightening values of respect, trust, and inclusivity.[17,33,37,41,42]

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. Some nurses empathized with involuntary migrant maternal women in their need to sustain their identities while learning a new language and integrating into a new sociocultural environment.[11] 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,[33] social workers[48] and interpreters.[15,18,33,36,41-43,46-48] Accessing translation services was described by some nurses as both beneficial and limiting. Benefits of working with interpreters included nurses being able to communicate clearly with women.[18,36] Channeling information through an interpreter provided some nurses with a sense of security that health information was being understood.[36] However, working with interpreters limited establishment of trusting relationships with women.[38]

Additional limitations involved nurses needing to be sensitive to cultural dynamics between interpreters and women. Once women expressed discomfort or mistrust of an interpreter, nurses within one study stated they would intervene and schedule a new appointment with a new interpreter.[36] Another significant limitation for nurses in this review was the inaccessibility of interpreters.[15,38] The amount of time needed for many nurses working in acute settings to find an interpreter was challenging.[48] When interpreters were not available in these settings, ultrasounds, x-rays, and blood tests were relied upon to visually communicate physical health issues among involuntary migrant maternal women. Interpreter inaccessibility was also described as challenging within acute care contexts involving rapid-paced care provision and use of technology that was unfamiliar to most involuntary migrant 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.*[48(p.6)]

Across health care settings, many 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.[38,43,46,48] Some nurses also described how words were not necessary "to see that someone cares for your child. The handling is quite universal."[46(p.2225)]

In the absence of interpreters, several nurses described approaches such as Google Translate and interpretation through family members as inadequate and inappropriate ways to communicate across language barriers.[34,46] Many nurses found that providing care through a family member led to mistranslation where women end up not receiving the entirety of health information being provided.[34]

Mistranslation and misunderstanding of information being provided were described by a number of nurses as compromising confidentiality and quality of care.[34,46,48] Ethical issues raised included ensuring confidentiality through conducting discreet sexual and reproductive health assessments.[33,34,42] Several nurses discouraged relying on family or friends for translation to preserve women's confidentiality.[36] In addition, many nurses scrutinized professional conduct of interpreters through observance of competent interactions with mothers and adherence to commitments of privacy.[36,39]

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

This synthesized finding was constructed through aggregation of two categories supported by 51 unequivocal findings (see Appendix V). Nurses' experiences of caring involved managing the effects of migrant policies that generated inequitable access to health and social supports among involuntary migrant maternal women. Mitigation of such inequities included addressing health determinants, such as social isolation and migrant status. Nurses' experiences of care demonstrated unique skill sets to assess pre-migration experiences and connect women to networks of social and health support. Further explanation of each category is described below.

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

This category was supported by 16 unequivocal findings describing nurses' views on how migrant status impacted women's health and affected care provision. Many nurses described ways to mitigate inequities stemming from migrant policies, including addressing social isolation as a health determinant hindered by limited access to social supports.[11,14,45] Although several nurses described receiving little formal training on how to assess a person's migrant status, nurses viewed migrant status as impacting women's broader health determinants.[11,35,48,49] Housing instability and living in poverty were often witnessed by many nurses where involuntary migrant maternal women had inadequate access to food and clothing.[11,33,40] Several nurses also recognized migrant policies as impacting receipt of fair and equitable care among involuntary migrant maternal 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!*[11(p.5)]

Many nurses observed migrant status as a barrier to accessing comprehensive health insurance, which consequentially hindered access to health care supports.[11,14,19,48] For example, several nurses observed that involuntary migrant maternal women avoided seeking prenatal care due to unaffordability.[11,14] Being ineligible for services addressing social isolation was also observed by some nurses as an impact of migrant status.[14,48]

While several nurses understood how migrant status affected service eligibility, they also described social isolation as a predisposing factor to postnatal depression among involuntary migrant women.[14,17] Many nurses voiced how caring for involuntary migrant maternal women included addressing depression and anxiety stemming from precarious migrant status and migration away from family supports.[17,35,45] Some nurses were aware of the importance of addressing isolation, especially among involuntary migrant women who were 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.[11,45] Care provision included spending time on understanding pre-migration experiences and geographical backgrounds.[11,33,43,45] Connecting women to local community was a strategy most nurses used to address lack of social support. Nurses centered their care on connecting women socially as well as to systems for health care provision.[33,43,47,48]

Category 2.2: Harnessing nursing knowledge to orchestrate care

This category was supported by 35 unequivocal findings where nurses described themselves as harnessing their understanding of complex maternal health issues and health systems to meet the health needs of involuntary migrant women. This understanding 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 that 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.[17,39,40,43,48] In doing so, most nurses found that they had to start from the beginning, as most involuntary migrant maternal women had little understanding of how health needs were addressed in their host country.[17,33,39,43] Several nurses described women's antenatal care as limited due to having diminished access to health services within war-torn countries.[39,49] These women were thereby considered as having high-risk pregnancies and needing care pathways fitting their complex needs. Most nurses found that they were among the first health providers contacted by involuntary migrant maternal women and provided a gateway for these women into the health system.[17,33,39,43] Ensuring timely maternal follow-up and close monitoring due to limited pre-migration antenatal care were thus viewed as critical to nurses' care provision.

Several nurses described their understanding of maternal health issues as significant to coordinating the appropriate care needed.[19,33,39,48] Nurses faced multiple complex health issues among involuntary migrant maternal women. One such complex issue involved exposure to trauma and violence. Some nurses described pre-migration trauma and violence as contributing to discomfort among involuntary migrant maternal women in conversing and receiving tests related to sexual and reproductive health.[33,34,42] While several nurses expressed a lack of comfort in knowing how to engage in women's experiences of trauma and sexual violence, care provision centered on being sensitive and attentive to women's emotional well-being during clinical interactions.[11,42] Many nurses emphasized the need for establishing trusting relationships with women to foster disclosure of experiences of trauma and violence.[14,33,42,45] Assurance of confidentiality and consistent emotional support were ways nurses established trust.

A number of nurses voiced understanding of relational care as essential to provision of care.[14,42,45] 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.[33] 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.[18,33,34,39] 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.[17,40,44,48,49]

Nurses described other constraints, including lack of organizational commitment to enhancing clinical processes so that more time could be allocated to care for women with multiple health issues.[17,44] Without capacity to spend time and energy with this group of women who often experienced serious trauma-related mental health issues, as well as language and cultural barriers, many 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).*[44(p.6)]

Listening to stories of the atrocities associated with forced migration left some nurses emotionally exhausted and traumatized. Receiving emotional support from informal sources, such as peers, was described as being a central need for nurses caring for involuntary migrant maternal women.[33]

Discussion

This synthesis of qualitative evidence summarized 115 findings from 23 critically appraised studies into two synthesized findings that captured geographical variation and diverse care delivery contexts. The generated synthesized findings were informed theoretically by intersectionality,[25] and magnify the knowledge nurses use and how nurses enact health care provision when working with complexities among involuntary migrant maternal 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 health care 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,[35,37,38] others embraced diversity through being open to new understanding of maternal health as well as being flexible in care delivery protocols.[17,41,45] 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.[52-54] Researchers have attributed culturally safe health care provision to equitable service delivery and better health outcomes.[55] 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 involuntary migrant women was voiced by nurses as challenging due to lack of organizational guidance.[11,33,44] Although the impacts of trauma on women's health have been well-documented,[56-59] current literature suggests that nurses are limited in their understandings of trauma-informed care practices.[60,61] 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 caring for women with multiple complexities, nurses engaged with health determinants that affected the well-being of involuntary migrant maternal women and their infants. Social isolation, impacts of exposure to trauma and violence, and diminished access to prenatal care (eg, due to limited health insurance and/or pre-migration contexts of conflict where access to health services was limited) were identified by nurses 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.[62,63] Despite having minimal training on understanding migrant status, many 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.[11,14,17,19,38,48] However, understanding the meaning of each migrant status category within the context of a country's migrant and health policies is essential to understanding how structural policies are contributing to inequitable health experiences among involuntary migrant maternal women.

In addition to capturing the diverse migrant status categories that described involuntary migrant women, the multiple roles assumed by nurse participants within studies included in this review were extracted. While many nurses' experiences centered around maternal–child nursing practice roles, it is significant to note the presence of other specialist practice roles, such as psychiatric nursing and chronic disease nursing. This finding highlights how maternal women with precarious migrant status can require complex care from specialist practices for health issues extending beyond the scope of maternal health and into other physical, emotional, or social needs. As a result, nurses working across health care 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's[16] findings that nurses need more education to care for the mental health needs among involuntary migrant maternal women. This finding also extends the ICN position[12,32] of nurses being central to refugee and migrant care within crisis contexts to include the multi-sectoral health care system contexts around the world.

More focus is needed beyond the crisis context to provide informed nursing care for involuntary migrant maternal women within transition and settlement care provision situations. Additionally, the ICN position statement[32] pays minimal attention to the presence of exposure to trauma and violence among involuntary migrant women. As a result, integration of trauma and violence-informed

competencies within international and local nursing associations is elemental to enhancing nursing practice and education.

Strengths and limitations

This review included studies that were limited in at least six ways: i) the small number of studies focused solely on nurses; ii) consideration of gender and race constructs; iii) geographical study distribution; iv) excluding studies published in languages other than English; v) exclusion of nurses caring for involuntary migrant women who experienced loss of pregnancy, loss of an infant, abortion, or other non-reproductive-related health issues; and vi) exclusion of midwives and/or nurse-midwives.

First, it was identified that many researchers included nurses as part of an interdisciplinary team of health care professionals, health care providers, maternity care professionals, or service providers.[11,14,17-19,34,35,38-42,44,45,47-49] Findings centered explicitly on nurses' experiences were extracted from the 18 studies that included nurses working within interdisciplinary team members as study participants. This occurred through identifying and extracting data, which were clearly stated by authors as derived from nurses' experiences. Therefore, a strength of this review is the inclusion of studies that explored nurses' experiences while working within contexts of interdisciplinary teams. However, the limitation within this review is the small number of studies found that solely focus on nurses experiences.[33,36,37,43,46] Effects of this limitation included reduced nurses' experiences and diminished contributions of nursing knowledge to health care sciences. Consequential to the prioritization 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 minimal mention of race and gender as a health determinant. This limitation surfaced through the theoretical guidance of intersectionality,[25] which purports the need to view experiences as complex where social variables including gender, race, and migrant status interplay to generate inequitable impacts. Since the rise of critical feminist theories such as intersectionality, gaps in literature have been confronted where axes of race and gender in particular have been ignored or superficially integrated.[64] Multiple forces are at play within this gap where race and gender intersect to reflect racism and oppression.[65] Current literature describes impacts of race, including discrimination, as fueling negative effects on the health of involuntary migrant population.[32,66] 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 understanding[67] 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 involuntary maternal migrant women.[67] 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 involuntary migrant populations.[12,32]

Lastly, geographic distribution of studies within this review centered 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 in Thailand and one in Bangladesh, this review does not reflect globally diverse approaches to inquiry, to nurse experiences of care provision among involuntary migrant maternal 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 relevant studies. 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 involuntary migrant maternal women who experienced pregnancy, birth, or post-birth. These criteria excluded nurses caring for involuntary migrant women's health in general, such as women who had experienced pregnancy loss, infant loss, abortion, or other non-reproductive-related health issues. Within this same limitation is the inclusion of those identified and educated as nurses as per the ICN definition. This excluded midwives who may work similarly to nurses, but whose discipline differs from nursing in its history and scope of practice.

Conclusions

The central objective of this review was to identify, appraise, and synthesize qualitative evidence inquiring into nurses' experiences of caring for involuntary migrant maternal women. The resulting meta-aggregation of appraised evidence generated two synthesized findings summarizing current knowledge: nurses integrate cultural and linguistic diversity within practice, and nurses assess for inequities resulting from forced migration on maternal women. The need for integrating understanding across the health care system sectors of how precarious migrant status impacts women's health is essential to provide informed nursing care. Articulating the presence of nurses within multidisciplinary teams, as well as the scope of their role, is essential to capturing the unique knowledge nurses use within varying contexts of care provision. While involuntary migrant maternal women are cared for within maternal health care environments, this review identifies diverse hospital-based and community care contexts where this population of women also receive care. This review also draws attention to the various ways nurses experienced the impacts of precarious migrant status among involuntary migrant maternal women.

The synthesized findings in this qualitative review reveal nurses' experiences of various challenges centered around providing care across cultural and linguistic diversity. Nurses oriented their care provision to women's cultural traditions and flexed protocols to create culturally safe approaches. Many creative strategies based on experiential learning were identified 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 and 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 the barriers women faced, thus allowing them to 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.[12,68] However, nurses voiced broader constraints to fulfilling their roles, including a lack of organizational commitment to the development of administrative and clinical processes targeting enhanced capacity among nurses.

The findings of this review have the capacity to inform migration and health policy through learning from the experiences of nurses who have identified health disparities among maternal women. The findings also have capacity to inform professional practice through providing continuous education opportunities related to understanding health determinants faced by involuntary migrant maternal 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 of the findings included. Confidence levels for the synthesized findings were assessed as moderate using the ConQual approach.[26] The following practice and policy recommendations have been graded according to the JBI Grades of Recommendations[69] and are based on the findings of this review.

- 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)

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 the effects of institutional policies on nursing care provision and on the health outcomes among involuntary migrant maternal 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 involuntary migrant maternal women.
- Further inquiry is needed to examine nurses' experiences of providing care to involuntary migrant maternal 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' understanding of how precarious migrant status impacts involuntary migrant maternal women's health. Within research inquiries involving interdisciplinary teams, it is recommended that nurses' voices are made distinct and explicit through articulation of their roles and unique knowledge base.

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Declarations

The authors of this review work to improve diversity and inclusion in research. All authors work within a critical feminist philosophy and adopted intersectionality as an analytical lens within this review.

SK's background is in public health nursing and her program of research is centered on forcibly displaced women's health and well-being.

LM's research and scholarship focuses on supporting pregnant and newly parenting women experiencing multiple adversities and their families in their transition to parenting. She holds a particular focus on the issue of substance use during pregnancy.

DB supports ongoing systematic review activities in addition to acting as a peer reviewer of *JBI Evidence Synthesis*. Her doctoral work focused on

registered nurses' and licensed practical nurses' experiences of working together.

Author contributions

This review is a component of SK's doctoral dissertation. Data extraction was completed independently; however, DB accessed extracted findings and provided consistent support and ongoing feedback. SK and DB collaborated on analysis design and performed the analysis under DB's supervision. Writing of the manuscript was conducted by SK with consistent support and supervision provided by DB and LM.

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Appendix I: Search strategy

CINAHL Complete (EBSCO)

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")	7894
#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 (EBSCO)

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 (United States National Library of Medicine)

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
	Immigrant 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
	Migrant 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
	Asylum seeker QT: "refugees"[MeSH Terms] OR "refugees"[All Fields] OR ("asylum"[All Fields] AND "seeker"[All Fields]) OR "asylum seeker"[All Fields]	13,644
	Forcibly displaced QT: forcibly[All Fields] AND displaced[All Fields]	131
	Immigrant OR migrant OR asylum seeker OR forcibly displaced	80,713
#2 - nursing	Nurse QT: "nurses"[MeSH Terms] OR "nurses"[All Fields] OR "nurse"[All Fields]	374,849
	Healthcare provider 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	Maternal QT: "mothers"[MeSH Terms] OR "mothers"[All Fields] OR "maternal"[All Fields]	416,467
	Woman 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 (Clarivate)

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"	1680
Limited to: scholarly peer-reviewed journals, English, January 2000 – January 2021 publication limits		

Gray 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"	7060
#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: Studies ineligible following full-text review

1. Burchill J. Safeguarding vulnerable families: work with refugees and asylum seekers. Community Pract. 2011;84(2):23-6.
Reason for exclusion: This study does not identify nurses as being included in sample and does not present all findings.

2. Chen C-I, Huang M-C. Exploring the growth trajectory of cultural competence in Taiwanese paediatric nurses. J Clin Nurs. 2018;27(23-24):4331-9.
Reason for exclusion: Although these nurses indirectly cared for families through their pediatric 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. Anthropol Med. 2015;22(2):191-201.
Reason for exclusion: Data presented in this study 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. Int J Nurs Pract. 2003;9(3):183-90.
Reason for exclusion: Did not inquire into caring for involuntary migrant maternal 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. J Immigrant Minority Health. 2016;18(2):428-35.
Reason for exclusion: Data presented in this study 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. Evid Based Nurs. 2019;22(3):80.
Reason for exclusion: Ineligible study design: commentary.

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. Sex Reprod Healthc. 2018;16:199-205.
Reason for exclusion: Unilateral focus on sexual and reproductive health; did not inquire into caring for involuntary migrant maternal women.

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. Int J Environ Res Public Health. 2018;15(1):174.
Reason for exclusion: Unilateral focus on sexual and reproductive health; did not inquire into caring for involuntary migrant maternal women.

9. Oucho JO, Ama NO. Immigrants' and refugees' unmet reproductive health demands in Botswana: perceptions of public healthcare providers. Sth Afr Fam Pract. 2009;51(3):237-43.
Reason for exclusion: Unilateral focus on sexual and reproductive health; did not inquire into caring for involuntary migrant maternal women.

10. Payne A. Sexual assault nurse examiner forensic examinations for immigrant victims: a case study. J Forensic Nurs. 2018;14(2):112-16.
Reason for exclusion: Ineligible participant population.

11. Ruiz-Casares M, Rousseau C, Laurin-Lamothe A, Rummens J, Zelkowitz P, Crépeau F, *et al*. Access to health care for undocumented migrant children and pregnant women: the paradox between values and attitudes of health care professionals. Matern Child Health J. 2013;17(2):292-8.
Reason for exclusion: Ineligible 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? Soc Sci Med. 2013;93:78-85.
Reason for exclusion: 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, *et al*. Compromised communication: a qualitative study exploring Afghan families and health professionals' experience of interpreting support in Australian maternity care. BMJ Qual Safety. 2016;25(4):1-9.
Reason for exclusion: Data presented in this study drew on experiences of midwives and medical practitioners; no findings on nurse experiences.

Appendix III: Data extraction instrument

Reviewer	
Title	
Author	
Year	
Journal	
Record number	
Study description	
Abstract only published in English?	____Yes ____N/A
Methodology	
Methods used	
Phenomena of interest	
• Participants are nurses • Participants care for involuntary migrant mothers	____Yes ____No ____Unsure Comments: ____Yes ____No Comments:
Other characteristics identified	
Health care setting	
Geographical setting	
Concept description	
• Nurses' roles • Involuntary migrant status categories	
Other characteristics identified	
Study findings	
Key findings	
Implications	
Reviewer comments	

Appendix IV: Characteristics of included studies

Study Location	Methodology	Participants	Phenomena of interest	Characteristics of involuntary migrant women	Health care setting	Role of nurse
Degni *et al.*, 2012[42] Finland	Qualitative: naturalistic descriptive	25 participants; 7 were nurses and identified as female	To explore physician, nurse, and 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 Migrant status described: refugee, asylum seeker, immigrant	Family planning and maternal clinics	Psychiatric nurse, family planning nurse, maternity nurse
Drennan and Joseph, 2005[33] London, United Kingdom	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 Migrant status described: refugee, asylum seeker	Community clinics	Health visitors
Ganann *et al.*, 2019[17] Toronto, Canada	Qualitative: interpretive descriptive	14 participants: number of nurses not explicated; some identified as women, as being immigrants, and as having experience with PPD	To explore service-provider perspectives on facilitators and barriers faced in providing accessible care for immigrant women with PPD; services provided by nurses described as first-contact services	Cultural minority; low literacy Migrant status described: perinatal immigrant, landed immigrant, family class, refugee, asylum seeking, newcomer	"Workplaces": although unclear, authors alluded to community care settings	Service provider
Jean-Baptiste *et al.*, 2017[14] Florida, United States	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) Migrant status described: Undocumented immigrant, immigrant	Funded program sites delivering the Maternal, Infant, and Early Childhood Home Visiting program	Home visitor, nurse
Kurth *et al.*, 2010[15] Basel, Switzerland	Mixed methodology	10 participants; 3 were nurses; 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 Migrant status described: asylum seeker	Women's clinic in Basel University hospital; quiet room in hospital or university	Nursing-midwifery team (nurses working with midwives)
Kynoe *et al.*, 2020[46] Norway	Qualitative: hermeneutic	8 nurses	Exploration of how immigrant mothers without a common language with health care 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 Migrant status described: immigrant	Hospital NICU ward; quiet room	Nurse, certified nurse specialist

(*Continued*)

Study Location	Methodology	Participants	Phenomena of interest	Characteristics of involuntary migrant women	Health care setting	Role of nurse
Leppälä *et al.*, 2019[49] 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 Migrant status described: asylum seeker, humanitarian migrant, quota refugee, newcomer	Public maternal health clinic; one participant interviewed at her home on request	Public health nurse, registered nurse, maternity care professional
Lyberg *et al.*, 2012[41] 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 Migrant status described: immigrant; migrant	Vestfold University	Public health nurse; specially trained in management of prenatal and postnatal care for women
Lyons *et al.*, 2008[38] Dublin, Ireland	Qualitative: grounded theory	27 participants; number of nurses not explicated	To explore the experiences of maternity service providers caring for ethnic minority women	Ethnic minority; ethnic and culturally diverse; racialized; limited literacy Migrant status described: new migrant; seeking asylum	3 public health maternity hospitals: antenatal clinic, postnatal and labor wards	Auxillary nurses
Ng and Newbold *et al.*, 2011[34] Hamilton, Canada	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 Migrant status described: immigrant	Local clinics and physician offices	Nurse practitioner; health professional
Nithianandan *et al.*, 2016[44] Melbourne, Australia	Qualitative	37 participants of diverse ethnic backgrounds; 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 Migrant status described: refugee; asylum seeker	Women's maternity and refugee health and well-being services	Maternal and child health nurses, perinatal mental health nurses, refugee health nurses
Origlia Ikhilor *et al.*, 2019[47] Switzerland	Qualitative: exploratory	22 participants; 2 were nurses; all identified as female	To describe allophone migrant women's experiences and health care professionals' perspectives of communication barriers faced within maternity care	Allophone (do not speak any official languages of host country) Migrant status described: allophone migrant; refugee; undocumented foreigner; asylum seeker	Unclear	Nurse; health care professional
Peláez *et al.*, 2017[11] Montreal, Canada	Qualitative: multiple case study	63 participants; 39 nurses (gender and migration history gathered but not differentiated among disciplines; 57 participants identified as female; 11 participants identified as migrants from non-Western countries)	To understand health care professionals' attitudes and perspectives towards newly arrived migrant women from non-Western countries who need maternity care	Sociocultural barriers; non-Western minority; experience of abuse, violence, and trauma; language barriers; financial hurdles; experience of discrimination and stigma Migrant status described: non-Western migrant; refugee; undocumented immigrant	Urban teaching hospitals: maternity unit (antepartum, birthing, and postpartum)	Health care professional; nurse; nurse manager

(*Continued*)

Study Location	Methodology	Participants	Phenomena of interest	Characteristics of involuntary migrant women	Health care setting	Role of nurse
Reynolds and White, 2010[39] England, United Kingdom	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 Migrant status described: women asylum seeker	Initial accommodation center	Nurse, health professional
Rifai *et al.*, 2018[36] Sweden	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; dependent on husband; weak social support system Migrant status described: immigrant	Child health centers	Public health nurses; registered nurses with specialist training in public health and child/adolescent health (min. 4 years university)
Riggs *et al.*, 2012[18] Melbourne, Australia	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 providers	Culturally and linguistically diverse; financially responsible for family living overseas Migrant status described: humanitarian migrant; refugee	2 different organizations	Maternal and child health nurses; refugee health nurses
Sarker *et al.*, 2020[40] Bangladesh	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 January 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%) Migrant status described: forcibly displaced, refugees	Health posts and primary health care centers within humanitarian settlement site (community of refugee camps)	Nurse, health provider, service provider
Seo, 2017[19] Chiang Mai, Thailand	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 Migrant status described: documented migrant worker; undocumented migrant; stateless people; non-citizen others; ethnic group; refugees	Antenatal clinic; government hospital	Nurses – antenatal, delivery, postpartum and neonatal care; obstetric nurses
Skoog *et al.*, 2017[37] Skåne, Sweden	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 Migrant status described: asylum seeker; immigrant	Child health center	Child health services nurse

(*Continued*)

Study Location	Methodology	Participants	Phenomena of interest	Characteristics of involuntary migrant women	Health care setting	Role of nurse
Teng *et al.*, 2007[35] Toronto, Canada	Qualitative: explanatory	16 participants; 4 were nurses; all nurses identified as female; some had immigrant backgrounds and histories of postpartum mood disorders	To explore health care workers' experiences of providing care to recently immigrated women suffering from PPD	Culturally and linguistically diverse; isolated; some women entering into country through arranged marriage; lack of spousal support Migrant status described: newcomer women, new immigrant	Agencies providing postpartum care to immigrant women	Public health nurse; registered nurse; practical nurse;
Willey *et al.*, 2018[43] Australia	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 Migrant status described: humanitarian entrants; refugees; asylum seeker	6 municipalities	Maternal and child health nurses
Winn *et al.*, 2018[48] Calgary, Canada	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 backgrounds Migrant status described: pregnant refugee women; Syrian refugee women	Refugee specialized, interdisciplinary clinic (Mosaic Refugee Health Clinic)	Chronic disease nurse, labor and delivery nurse, health care provider
Yelland *et al.*, 2014[45] Melbourne, Australia	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 Migrant status described: humanitarian entrant; refugee	Unclear	Refugee health nurse; maternal and child health nurse; health professional; community-based care provider; early childhood nurse

NICU, neonatal intensive care unit; PPD, postpartum depression.

Appendix V: Meta-aggregation tables

Findings (n=64)	Categories (n=2)	Synthesized finding 1
Health challenges: Differing expectations of support (U)	Centering care around culture	*Nurses integrate cultural and linguistic diversity within practice* Nurses' experiences demonstrated the need for 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 delivering culturally sensitive care. Addressing linguistic diversity within nurses' experiences included careful use of interpreter services and exploring approaches to universal demonstration of care.
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": Racism (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)		

(*Continued*)

Findings (n=64)	Categories (n=2)	Synthesized finding 1
Cultural challenges: Linguistic barriers and inconsistency in the use and quality of the interpretation service (U)	Communicating through language barriers	
Interpersonal level: Pivotal role of the PHC provider – acknowledging language complexity (U)		
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 – effects on rapport (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)		

(*Continued*)

Findings (n=64)	Categories (n=2)	Synthesized finding 1
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 (U)		
Social isolation: Language barrier (U)		

U, unequivocal; MCH, maternal and child health; PHC, primary health care; PPD, postpartum depression; PTSD, post-traumatic stress disorder.

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	*Nurses assess for inequities resulting from forced migration on maternal women* Nurses' experiences of caring involved managing the effects of migrant policies that generated inequitable access to health and social supports among involuntary migrant maternal women. Mitigation of such inequities included addressing health determinants such as social isolation and migrant status. Nurses' experiences of care demonstrated unique skill sets to assess pre-migration experiences and bridge women to networks of social and health support.
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)		

(*Continued*)

Findings (n=51)	Categories (n=2)	Synthesized finding 2
Receiving adequate care: 'You were lucky if you got into the basic maternal health care there' – feeling overworked (U)	Harnessing nursing knowledge to orchestrate care	
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 and 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)		

(*Continued*)

Findings (n=51)	Categories (n=2)	Synthesized finding 2
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)		

U, unequivocal; FDMN, Forcibly Displaced Myanmar Nationals; MCH, maternal and child health; MNCH, maternal, newborn, and child health; PPD, postpartum depression.

Appendix VI: Study findings and illustrations

Degni F, Suominen S, Essén B, El Ansari W, Vehviläinen-Julkunen K. Communication and cultural issues in providing reproductive health care to immigrant women: health care providers' experiences in meeting Somali women living in Finland. J Immigr Minor Health. 2011;14(2):330-43.[42]	
Finding 1	Nurses/midwives–Somali women relationships
Illustration (U)	"To build up a good relationship with Somali women, do not ever start talking about contraception or their religion (Islam) to them until they are the first to talk about those things"(p.335)
Finding 2	Nurses/midwives–Somali women relationships: Building trust
Illustration (U)	"The best way to know each other is to build up trust, visit them in their homes, listen and support them psychologically"(p.335)
Finding 3	Nurses/midwives–Somali women relationships: Language barrier
Illustration (U)	"It is difficult to communicate with the Somali women, because they do not understand Finnish and one cannot talk with them directly, one always needs an interpreter"(p.336)
Finding 4	Nurses/midwives–Somali women relationships: Cultural understandings
Illustration (U)	"Hugging and touching are not ordinary parts of Finnish culture. Now, we have learned and understood the cultural meaning of hugging the Somali women, so that some of us can do it more easily than before"(p.336)
Finding 5	Nurses/Midwives' perceptions about Somali women's cultural attitudes to reproductive health care
Illustration (U)	"We are sure that with changes in the social and cultural adaptation, many more will follow in the coming years in order to compromise between religion, culture and the use of contraception including abortion and sterilization as birth control methods"(p.338)
Drennan V, Joseph J. Health visiting and refugee families: issues in professional practice. J Adv Nurs. 2005;49(2):155-63.[33]	
Finding 6	Complexity of the relationship between health visitors and clients who are refugees
Illustration (U)	"It is really about just the complexity in trying to get information in the very short space of time, because they move on quickly,"(p.159)
Finding 7	Complexity of the relationship between health visitors and clients who are refugees: Dispelling fears
Illustration (U)	"I always make it clear I am nothing to do with the Home Office or passports, because, you know, many refugees are very frightened. They don't know I am a health visitor, – I could be the Passport Office right hand woman for all they know. (Interview 5)," (p.158)
Finding 8	Complexity of the relationship between health visitors and clients who are refugees: Explaining the system
Illustration (U)	"Working with the indigenous population, one goes in to confirm the system. This is very different when working with the refugees who have no knowledge of the system, so you have to start from the beginning. (Interview 13),"(p.159)
Finding 9	Complexity of the relationship between health visitors and clients who are refugees: Understanding culture
Illustration (U)	"You know, I would never expect to understand a culture, because it is hard enough if you have lived there. But there is a sort of... working relationship which is mutually respectful. (Interview 11),"(p.159) "Now one thing I always do when I do my visits is to ask through the interpreter, you know, ask them if they want to tell me about what their practices are,"(p.159)
Finding 10	Identification and prioritization of health needs
Illustration (U)	"...They had been given a cot but they had no blanket, they had barely anything for the bed. She had no nappies, no clothes and no money and she was seriously struggling with breastfeeding...she [the refugee mother] needs money, she needs milk, she needs a steriliser, she needs clothes and she needs it now. (Interview 4),"(p.159)

Finding 11	Identification and prioritization of health needs: Considering war context
Illustration (U)	"I think it's quite difficult for refugee women to understand the services around sexual health and contraception. Having to explain about smear testing, whereas in their own country there isn't a programme. Women can be very reluctant. . .and taking a smear is very invasive, isn't it. . .and you don't know what's happened to them before they got here.,"[p.160]; ". . .I generally work on the assumption that they're likely to have some element of depression anyway, because of their circumstances,"[p.160]
Finding 12	Health visitors' perceptions of successful outcomes of their work
Illustration (U)	". . .This family had problems. They've been victims of torture in [country] and also the father of the family had been beaten up over here in a racist incident as well. . .I managed to work with an advocate they had a lot of confidence in. Anyway, I then worked with the psychologist with that family around the eating problem,"[p.161]
Finding 13	Impact on health visitors of working with refugee families
Illustration (U)	"But last year I did find it very traumatic to work with [country] families. . . because some of the stories that you hear are, you know, absolutely horrendous,"[p.161]
Ganann R, Sword W, Newbold K, Thabane L, Armour L, Kint B. Provider perspectives on facilitators and barriers to accessible service provision for immigrant women with postpartum depression: a qualitative study. Can J Nurs Res. 2019;51(3):191-201.[17]	
Finding 14	Intrapersonal level: Provider attributes - understanding women's experiences
Illustration (U)	Providers also stressed important differences between recent immigrants and those who have lived in Canada longer; for newcomers, "the level of isolation is quite different,"[p.194]
Finding 15	Intrapersonal level: Provider attributes - enacting cultural competence
Illustration (U)	Providers talked about the importance of flexible service delivery approaches to embrace diverse cultural practices. . .One provider explained, "It's helping to massage your own policies and not stretching them or changing them but helping our own policies and procedures to accommodate a different culture, a different way of thinking,"[p.194]
Finding 16	Intrapersonal level: Provider attributes - providing system navigation
Illustration (U)	"We have to sort of break down all the tentacles of a system and the barrier for workers. . .we don't know all the tentacles for other agencies,"[p.194]
Finding 17	Interpersonal level: Relationship approaches - building trust
Illustration (U)	Providers emphasized that trust is at the core of accessible service provision and is foundational to women partnering in care and enacting any advice given. One stated that a "therapeutic alliance, it changes with every family, but it is the key for me in helping a parent with postpartum, which isn't the key for all systems,"[p.195]
Finding 18	Interpersonal level: Pivotal role of the PHC provider - acknowledging language complexity
Illustration (U)	"Now if you were a person who didn't speak English, weren't able to advocate for yourself and were not persistent, you would give up that struggle to find somebody who can help you,"[p.195]
Finding 19	Intrapersonal level: Provider attributes - adequate time to disclose
Illustration (U)	"If the person is struggling with words or trying to find the right words to explain themselves. . .and 15 minutes for an appointment doesn't cut it",[p.194]
Finding 20	Organizational level: Addressing barriers to accessing care
Illustration (U)	One provider emphasized the importance of "making sure they have those linkages in the community so that they are not isolated," [p.196]
Finding 21	Organizational level: Supports and pressures for service coordination
Illustration (U)	Others did not feel support from their organizations to enact [working collaboratively with other multidisciplinary service providers]; one provider stated, "We don't get credit for service coordination from an agency point of view,"[p.196]

Jean-Baptiste E, Alitz P, Birriel P, Davis S, Ramakrishnan R, Olson L, et al. Immigrant health through the lens of home visitors, supervisors, and administrators: the Florida maternal, infant, and early childhood home visiting program. Public Health Nurs. 2017;34(6):531-40.[14]	
Finding 22	Social isolation: Language barrier
Illustration (U)	"The fact that they're [immigrants] and have no health insurance; they don't go to prenatal care, and they don't go seek services because—I mean, I've tried to navigate the community, and I speak English, and it's impossible. I can't imagine not speaking the language,"(p.536)
Finding 23	Access to care and services utilization
Illustration (U)	"It's still a challenge though because the services that are available to the people that are... U.S. citizens are not always available... So we are more challenged to meet their needs...,"(p.537)
Finding 24	Mistrust of formal systems
Illustration (U)	"In the very beginning, they're usually reluctant until they build that trust... Once they know who they can trust and tell me things and it's confidential and that I can help them; then that relationship becomes very strong...",(p.537)
Kynoe NM, Fugelseth D, Hanssen I. When a common language is missing: nurse–mother communication in the NICU a qualitative study. J Clin Nurs. 2020;29(13-14):2221-30.[46]	
Finding 25	Communication and caregiving despite lack of a common language
Illustration (U)	"We talk, and nod and smile and you get some kind of communication and we have the baby I common and you talk to the baby: 'we'll change [your] diaper'"(p.2225)
Finding 26	Communication and caregiving despite lack of a common language: caring as universal
Illustration (U)	"one is not dependent on a common language to see that someone cares for your child. The handling is quite universal,"(p.2225)
Finding 27	Using different communication strategies
Illustration (U)	"some words that we knew she could understand, because then we could point [things] out to them. It gets very basic, but one could at least come a step further in everyday [situations]"(p.2226)
Finding 28	Using different communication strategies – communicating reassurance as challenging
Illustration (U)	"things that we [as nurses] perceive as trifles may seem like a disaster to the mothers because they do not understand what it is... Just watching the monitors may be scary.... How are you going to [explain] with body language? [When a monitor alarm goes off] we can be perceived as plunging in on the monitor and Mum gets scared while the nurse is smiling at her! The message changes from sender to recipient and then it becomes completely wrong,"(p.2226)
Finding 29	Using different communication strategies – not knowing mothers' backgrounds
Illustration (U)	"it was problematic not knowing the mothers' backgrounds. Were they from urban areas and used to hospitals or from rural areas where they do not have so much technical equipment?"(p.2226)
Finding 30	Bedside communication tools and interpreters
Illustration (U)	"we tend to use interpreters for [meetings] with doctors only... but you want to be part of the conversation and inform about discharge and so on, too. I, at least, have not experienced that we have used interpreters for guidance and bedside information [and thus reach the same quality of care] as we usually do with majority mothers,"(p.2226)
Finding 31	Bedside communication tools and interpreters – mistranslation through family interpreters
Illustration (U)	"Dad interprets what he thinks mother needs to know. So, mother does not know about the small nuances that may be important to her when she is back home on leave with the sick child,"(p.2227)
Finding 32	Bedside communication tools and interpreters – mistranslation through technology
Illustration (U)	"I used Google Translate once when trying to explain that the baby was having specific symptoms, but this was not what came up on Google Translate. Mom said in very broken English that it meant something completely different, so I do not think Google Translate is a good tool... but in the end you use whatever may be helpful,"(p.2227)

Kurth E, Jaeger F, Zemp E, Tschudin S, Bischoff A. Reproductive health care for asylum-seeking women - a challenge for health professionals. BMC Public Health. 2010;10(1):1-11.[15]	
Finding 33	Psychosocial issues for asylum-seeking women and challenges to the health care professionals: Challenges for health care providers - Language and cultural barriers
Illustration (U)	"The language barrier is an enormous problem. . .so (when we have no interpreter available) we look to see whether there is anyone who works in the hospital who knows this particular language. . .But this is not always possible. And then you have to do the best you can and simply get on with the investigations and ultrasound and all that. And somehow you get a picture of this pregnancy and this woman,"(p.6)
Leppälä S, Lamminpää R, Gissler M, Vehviläinen-Julkunen K. Hindrances and facilitators in humanitarian migrants' maternity care in Finland: qualitative study applying the three delays model framework. Scand J Caring Sci. 2019;34(1):148-56.[49]	
Finding 34	Receiving adequate care: 'You were lucky if you got into the basic maternal health care there' - Feeling overworked
Illustration (U)	"It took, yeah, the whole working day, the different requirements. Of course, when you had to think everything through, starting from the temporary person numbers. And there were many different stakeholders there around, we co-operated with the laboratory and x-ray, and first aid and. . . With the. . .and with the emergency care and reception staff too. (PHN4)",(p.154)
Finding 35	Decision to seek care: 'Whoever holds the language' - making first contact
Illustration (U)	"The first contact, the booking, it always has come through the nurses, no, in no case has it been so that the mother would walk in and say, show (shows a round movement with her hand over her belly), that she'd be pregnant. The nurse reserves the appointment. (PHN2)",(p.152)
Finding 36	Receiving adequate care: 'You were lucky if you got into the basic maternal health care there' - dealing with chaos
Illustration (U)	"The first newcomers, many of them were pregnant. And then, the change, of course, that followed, we right away had to go and find out about those things. And quite many challenges there were, in the beginning, since all of that, it added up to the rest of our work. And quite chaotic it was, the beginning - honestly said, it was chaotic. (PHN2),"(p.154)
Finding 37	Receiving adequate care: 'You were lucky if you got into the basic maternal health care there' - dealing with migrant movement
Illustration (U)	"So, the refugees, they started to come in the year 2016, and I came in (around the same time) to this MHC, so here, they belonged in my job description - the refugees' check-ups, and all of that, implementing the vaccinations. . . So, in the beginning they were quite closely here at my reception. (PHN3),"(p.153)
Lyberg A, Viken B, Haruna M, Severinsson E. Diversity and challenges in the management of maternity care for migrant women. J Nurs Manag. 2011;20 (2):287-95.[41]	
Finding 38	Health challenges: Differing expectations of support
Illustration (U)	". . .many are not used to talking about their feelings. When the physical examination is over they get dressed and prepare to leave the room,"(p.290)
Finding 39	Health challenges: Diversity in education and knowledge
Illustration (U)	". . .Yes, I have noted that posters with an overview of the female body can be too abstract for some women. . .We might try video-tapes instead. Then those who want can bring the film home and watch it in privacy,"(p.291)
Finding 40	Health challenges: Emotional pain
Illustration (U)	". . .it's also important to focus on what they can manage. . . I can be more concerned about their difficulties than they are. They work hard to keep the sad feelings at bay and look ahead. They care for their children and are occupied with being as normal as possible,"(p.291)
Finding 41	Cultural challenges: Linguistic barriers and inconsistency in the use and quality of the interpretation service
Illustration (U)	". . .but it's completely wrong to use men, they don't have the words we use in their vocabulary,"(p.292)
Finding 42	Cultural challenges: Relational diversity - building trust
Illustration (U)	". . .the important element for trust is to respond to the woman's needs and try to understand her codes, culture and religion,"(p.292)

Finding 43	Cultural challenges: Lack of assets for social integration
Illustration (U)	"Some are active and search for contact. Others come from cultures that do not allow them to socialize with all classes of people and there can be incompatibilities between people from the same country,"[(p.293)]
Finding 44	Cultural challenges: Promoting the women's health and well-being
Illustration (U)	". . .Yes, if we take initiatives it is very important to ask the women what they want,"[(p.293)]
Lyons S, O'Keeffe F, Clarke A, Staines A. Cultural diversity in the Dublin maternity services: the experiences of maternity service providers when caring for ethnic minority women. Ethn Health. 2008;13(3):261-76.[38]	
Finding 45	Communication difficulties: Lack of proficiency in the English language - Effects on rapport
Illustration (U)	"If it was an emergency case they generally understand, you can make them understand about what you are going to do and you know, they can nod or say no if they don't want it. . ."[(p.265)]
Finding 46	"Them and Us": Different to us
Illustration (U)	". . . [they] are different to our own Irish ladies,"[(p.268)]
Finding 47	"Them and Us": Racism
Illustration (U)	". . . you don't want them to think that maybe because of their colour that perhaps you are checking more than you normally would with someone else"[39(p.269)]
Finding 48	Communication difficulties: Lack of proficiency in the English language - Effects on rapport
Illustration (U)	". . . you just wonder what is going on with them. You can't get a rapport with them. I mean if you can't speak their language, you know. . . you can't establish any rapport. It is very hard to build up confidence and they just look frightened a lot of the time,"[(p.265)]
Finding 49	Communication difficulties: Use of informal interpreters
Illustration (U)	"Sometimes it is like if that person is alone [and cannot speak English] Oh my God! So you just try to speak in English really slowly and do signals explain what you are going to do and how can you explain 'I am going to do an [vaginal] examination'?"[(p.265)]
Finding 50	Communication difficulties: Use of professional interpreters
Illustration (U)	"Well I know that translation services are available, I know they are there if we need them and we can get them. The problem is that they are never there when you need them",[(p.265)]
Finding 51	Cultural differences: Death of an infant
Illustration (U)	"I also feel at a bit of a disadvantage. . . that there isn't a lot of information available on people's beliefs, say when they have a bereavement. . .Whether they believe "well it is dead, it's dead and there's no more about it" whereas if it was an Irish woman we would encourage her that she look at her baby and that she should name her baby and that she should identify it as a person. And I don't want to push what I believe what we do for the Irish women is correct. . . And that's one place where I feel I have a big disadvantage,"[(p.268)]
Ng C, Newbold K. Health care providers' perspectives on the provision of prenatal care to immigrants. Cult Health Sex. 2011;13(5):561-74.[34]	
Finding 52	Expectation of language
Illustration (U)	"Now women who don't have access to care because they don't speak the language. . . I mean, they come and sit in front of you, but they don't actually really have access because they can't talk to you, you don't talk to them,"[(p.564)]
Finding 53	Expectation of language: compromised care
Illustration (U)	"Care is also compromised by people simply not understanding what the words mean and understand. . . so, sometimes, with people who don't understand English words, so it is hard, so they can't translate. And even if they can translate, sometimes they still don't understand the word. That can be very difficult,"[(p.565)]
Finding 54	Expectation of language: protecting confidentiality
Illustration (U)	"[This] is not ideal because there is confidential information, even such as past pregnancies. So, maybe. . . a woman has had. . . some women have had multiple – even one, but multiple abortions. . . . So, she might not want her mother-in-law knowing that; she might have had a sexually transmitted infection. So is she going to be honest if her mother-in-law is sitting beside her?"[(p.565)]

Finding 55	Expectations of provider type and level of professionalism
Illustration (U)	". . .another nurse practitioner, recounted a conversation with a patient: "Well, you're a nurse. How can you be looking after me? You are not a doctor. I need to see the doctor." And, "I am getting second-rate care because I am seeing a nurse, just a nurse." Nurse practitioners often find themselves in a position where they need to explain their role to their patients, which encompasses maintaining and monitoring the health of both the mother and the unborn child during pregnancy,"[p.567]
Finding 56	Expectations of provider type and level of professionalism: avoiding assumptions
Illustration (U)	"And perception, I think, from where they are going to go, because I think, again, our society sort of has a lot of preconceived notions. And so there is. . . if somebody is presenting very late, the idea is, 'Oh, what a bad mom',"[p.569]
Nithianandan N, Gibson-Helm M, McBride J, Binny A, Gray K, East C et al. Factors affecting implementation of perinatal mental health screening in women of refugee background. Implement Sci. 2016;11(1):150-62.[44]	
Finding 57	Knowledge: assessing impact of PTSD
Illustration (U)	"HPs explored exacerbation of PTSD symptoms in pregnancy and its: . . .significant impact on how women cope with pregnancy in terms of antenatal appointments. . . physical examinations. . . (ID 22; HP),"[p.4]
Finding 58	Beliefs and capabilities: assessing trauma
Illustration (U)	"I don't know how I would personally ask somebody if they'd experienced trauma. (ID 13; HP),"[p.6]
Finding 59	Environmental context and resources: having time
Illustration (U)	"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),"[p.6]
Finding 60	Social influences
Illustration (U)	". . .making sure that the husband or other family members are okay with. . . the woman attending this type of referral,"[p.7]
Finding 61	Behavioural regulation: following up
Illustration (U)	". . .the most important thing is follow-up. . . that if someone doesn't turn up for their appointment, that that's flagged. . .and that they're contacted. (ID 2; HP),"[p.7]
Origlia Ikhilor P, Hasenberg G, Kurth E, Asefaw F, Pehlke-Milde J, Cignacco E. Communication barriers in maternity care of allophone migrants: experiences of women, healthcare professionals, and intercultural interpreters. J Adv Nurs. 2019;75(10):2200-10.[47]	
Finding 62	Communication breakdown
Illustration (U)	"What I find difficult after having organized an interpreter any number of different people come: nurses, the midwife, the paediatrician, the obstetrician. . . How can the woman take it all in such a short time? But we're not allowed to have an interpreter twice, so we're all packed into one meeting. (Nurse),"[p.2205]
Peláez S, Hendricks KN, Merry LA, Gagnon AJ. Challenges newly-arrived migrant women in Montreal face when needing maternity care: Health care professionals' perspectives. Global Health. 2017;13(1):5-14.[11]	
Finding 63	Canadian standards of maternity care: inequities in status
Illustration (U)	"And for migrant women who are pregnant, the 'Canadian status' is crucial because that opens or closes access to free health care. If you have a 'Canadian status,' no matter which one, you get access to care. Now, if you don't have access to health care, no matter what, you can come and deliver, there is no question about it. But they have to pay, you know? So we don't deal with them anymore, just because the hospital now asks for money upfront for deliveries. But we used to have undocumented immigrants, a while ago, not now. Those people are still around, but we don't see them because they have to pay for everything, even for prenatal screenings",[p.5]
Finding 64	Challenges migrant women face concerning health care: meeting cultural needs
Illustration (U)	". . .when it comes to sociocultural issues it's really hard for them because in addition to not having the language and feeling isolated, the only way you have to be emotionally linked to your family is by means of your rituals, your traditions, your beliefs. And for different reasons, usually genuine reasons, we have a hard time to respect them. . .we cannot please them with these requests because of the law and regulations,"[p.5]

Finding 65	Canadian standards of maternity care: engaging with prejudice
Illustration (U)	"So she's not a priority because if she gets the care, who is going to take care of the kids?... I frequently ask myself whether these prejudices are going to stop... We tried education; we trained some of our professionals on multicultural issues...Well, it minimized the negative impact, but it is still there,"(p.6)
Finding 66	Canadian standards of maternity care: questioning equitable care provision
Illustration (U)	"...as a health care professional, I say to myself: "Just be fair and provide equal care." Now, you pushed me to think about this...What is equal care? Is it the same we give to everyone, but does not respect these women's stories?... If this is it, truly, more than being guided by my intuition I really don't know what to do because there are so many factors conflating that I really don't know how to proceed,"(p.6)
Finding 67	Women's start-up conditions at the time of needing maternity care
Illustration (U)	"I would say that in my experience, newly-arrived migrant women, even if they are close to delivery, have many things in their minds other than giving birth, such as housing, food, clothing, and education for their children,"(p.4)
Finding 68	Challenges migrant women face concerning health care: acknowledging trauma and violence
Illustration (U)	"...you are escaping from an abusive situation, you are probably poor, coming from a violent country, and leaving behind traumatic stories of suffering, repression,"(p.5)
Finding 69	Challenges migrant women face concerning health care: appreciating cultural and language difference
Illustration (U)	"...the language spoken in the receiving country has no similar roots, not even the same alphabet; the culture is completely different and as you didn't anticipate coming here,"(p.5)
Finding 70	Canadian standards of maternity care
Illustration (U)	"...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!"(p.5)
Reynolds B, White J. Seeking asylum and motherhood: health and wellbeing needs. Community Pract. 2010;83(3):20-3.[39]	
Finding 71	Health needs: complexity
Illustration (U)	"They are all 'high-risk' women, so they all need high-risk, consultant-led care... They are late bookers, 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",(p.21)
Finding 72	Women in transition: navigating system
Illustration (U)	"A large part of my job is priming people, telling them over and over that when they are dispersed, one of the first things they need to do is to register with a GP and midwife",(p.21)
Rifai E, Janlöv A, Garmy P. Public health nurses' experiences of using interpreters when meeting with Arabic-speaking first-time mothers. Public Health Nurs. 2018;35(6):574-80.[36]	
Finding 73	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
Illustration (U)	"I can almost speak with the [Arabic-speaking first-time] mother face-to-face... across from each other, and the interpreter just talks as my second voice. It has been really important. It is a very good aid, very good...,"(p.576)
Finding 74	Having to accept and learn to incorporate interpreters when meeting with Arabic-speaking first-time mothers: Contributing to a trustful relationship
Illustration (U)	"It is a form of security for the mother to get a translation and to be understood. It is also security for me in my professional role, first and foremost to confirm that this is okay, that this dialogue is working. Then, I do not need to worry, and then the mother does not need to worry either,"(p.577)
Finding 75	Having to accept and learn to incorporate interpreters when meeting with Arabic–speaking first-time mothers: Creating disturbing elements in the dialogue
Illustration (U)	"I observe the mother all the time. If I notice that she is not comfortable with the interpreter, then, of course, I do schedule a new appointment with another interpreter as soon as possible,"(p.577-8)

Finding 76	Having to accept and learn to incorporate interpreters when meeting with Arabic-speaking first-time mothers: Creating disturbing elements in the dialogue - ensuring confidentiality
Illustration (U)	"Many mothers have a fear that the interpreters would discuss what they had been told to others, even if the interpreter has professional secrecy. Some interpreters cannot maintain confidentiality. We have seen that, and, therefore, I do want interpreters that I can rely on and that I trust,"[p.578]
Riggs E, Davis E, Gibbs L, Block K, Szwarc J, Casey S et al. Accessing maternal and child health services in Melbourne, Australia: reflections from refugee families and service providers. BMC Health Serv Res. 2012;12(1):117-33.[18]	
Finding 77	Promoting continued engagement with the MCH service: Continuity promotes engagement
Illustration (U)	"Continuity of staff is another thing, because if you see, every time you come, if you have a problem and you see a different person you're going to disengage with the service because you don't want to be going over the same things. Yes, I do have mums saying "I don't want to have to repeat this over and over." (MCH nurse),"[p.9]
Finding 78	Promoting continued engagement with the MCH service: Working with interpreters
Illustration (U)	"The phone interpreter is too impersonal. And I found that a lot of them use mobile phones so you're constantly cutting out. You don't know who this person is. And if you end up using the same interpreters on a regular basis then the mothers get used to the interpreters and vice versa and you can build a really nice relationship. (MCH nurse),"[p.9]
Finding 79	What is working well and what can be done better: Co-location of services
Illustration (U)	"So if you've got. . .a hub, a population, you need to have the English classes in the same building rather than have to have them go somewhere else. One stop shopping, if we can do that they will manage a lot easier. So if they need counselling they can meet the counsellor, so they're not going off to some strange place to see a counsellor to talk about all their traumas, they can actually know that this person they've met, they've seen and they're already in the same building. (MCH nurse),"[p.11]
Sarker M, Saha A, Matin M, Mehjabeen S, Tamim MA, Sharkey AB, et al. Effective maternal, newborn and child health programming among Rohingya refugees in Cox's Bazar, Bangladesh: implementation challenges and potential solutions. PLoS One. 2020;15(3):e0230732.[40]	
Finding 80	Challenges and potential solutions to MNCH service delivery among FDMNs: Challenges - Security
Illustration (U)	". . .This Rohingya community is very violent. If there is any dispute over some issues, they become very dangerous. You really cannot tell what will happen when you are going to work or walking on the road,"[p.8]
Finding 81	Challenges and potential solutions to MNCH service delivery among FDMNs: Implementation process – Service delivery
Illustration (U)	"There have been some areas where services are overlapping, and underutilization fo resources is happening in other facilities. Different organizations for the same beneficiaries deliver similar activities,"[p.9]
Finding 82	Challenges and potential solutions to MNCH service delivery among FDMNs: Implementation process – Referral
Illustration (U)	"The lack of capacity of the referral health facility is a problem. Upazila Health Complex is a 50 bedded hospital. Sometimes the patient load is high. Therefore, they provide initial treatment and send the FDMN clients back home,"[p.9]
Finding 83	Challenges and potential solutions to MNCH service delivery among FDMNs: Human Resource – Capacity building
Illustration (U)	"Yes, those who are newcomers, they might not be knowledgeable about everything. They are continuously learning, and the older ones are helping them with it. We are giving them guidance. Problems are also being solved almost immediately by arranging formal training and meetings,"[p.13]
Seo BK. The work of inscription: antenatal care, birth documents, and Shan migrant women in Chiang Mai. Med Anthropol Q. 2017;31(4):481-98.[19]	
Finding 84	Mutual obligation to care
Illustration (U)	"They listen to us, and are willing to know how to take care of their pregnancy. . . we advise them about good eating habits during pregnancy and breastfeeding. . . happens. These people are relying on us, and it's very rewarding to provide antenatal care to Shan women,"[p.488-9]
Finding 85	Mutual obligation to care: equal care provision
Illustration (U)	"We have to take care of everyone equally whether they are insured or not,"[p.489]
Finding 86	Mutual obligation to care: ensuring correct documentation
Illustration (U)	"We need to record everything correctly. Otherwise the baby's birth document will contain misleading information,"[p.490]

Skoog M, Hallström I, Berggren V. 'There's something in their eyes' - Child Health Services nurses' experiences of identifying signs of postpartum depression in non-Swedish-speaking immigrant mothers. Scand J Caring Sci. 2017;31(4):739-47.[37]	
Finding 87	Interpreting the mother's mood using cultural knowledge
Illustration (U)	"So we look the baby straight in her eyes, but her mother, she doesn't look her in the eyes and then we come to the conclusion that the mother must be depressed,"(p.742)
Finding 88	Establishing a transcultural supportive relationship
Illustration (U)	". . . that they feel that I welcome them as I welcome any fellow human being and that I don't look down on them or think that they are different, but that we. . . I was about to say become friends, but it's the wrong word. . . but that we have a good relationship. That they feel they are liked and that I listen to them. I think that's the main thing [. . .] then they trust me [. . .] that's how I think it works (no. 6),"(p.741)
Finding 89	Establishing a transcultural supportive relationship: health promotion approaches
Illustration (U)	"I have many immigrant parents who like to be given hands-on advice, if it doesn't work try this and try that. The younger nurses might not be doing this, instead they want the parents to figure out the solution themselves and isn't always that easy for them (no. 12),"(p.741)
Finding 90	Striving – sometimes in vain – when screening for PPD
Illustration (U)	"It's 'us and them'. I am an authority figure to them. Other cultures keep things in the family and if you aren't feeling well or have a problem you don't go to an authority figure like we Swedes do; you turn to your mother or mother-in-law. (no. 8),"(p.743)
Finding 91	Striving - sometimes in vain - when screening for PPD: feeling frustrated
Illustration (U)	"You can be pretty tired afterwards and feel that you give and you give. Even if you don't say that much, it still takes a lot of energy because you have to be in the here and now and kind of give of yourself all of the time. I think you sometimes feel really exhausted afterwards (no. 10),"(p.744)
Teng L, Robertson Blackmore E, Stewart D. Healthcare worker's perceptions of barriers to care by immigrant women with postpartum depression: an exploratory qualitative study. Arch Womens Ment Health. 2007;10(3):93-101.[35]	
Finding 92	Culturally determined barriers
Illustration (U)	"Some cultures tend to believe that depression of any kind is a form of madness. Those who admit to suffering from depression after the joyous birth of a baby – especially of a boy – are labeled 'crazy',"(p.97)
Finding 93	Fear of incompetence: training versus experience
Illustration (U)	". . .actually, I don't think formal training would do much good. In the end you need to gain experience to achieve a sense of competence, and you need to always keep an open mind in terms of what you're seeing,"(p.98)
Finding 94	Cultural uncertainty
Illustration (U)	". . .it can be harder trying to understand the experience of someone who may have led a very different life from you [compared to understanding the experience of someone of the same cultural background]. . .they may have very different expectations or understandings,"(p.98)
Willey S, Cant R, Williams A, McIntyre M. Maternal and child health nurses work with refugee families: perspectives from regional Victoria, Australia. J Clin Nurs. 2018;27(17-18):3387-96.[43]	
Finding 95	How to identify women from a refugee background: strategy
Illustration (U)	"Others felt confident in asking in a sensitive way: I've actually got a huge map of the world. . . I ask them to point to it [where they're from], I mean, I know where most of them are from, but just to sort of help them, I say 'Can you show me where you're from?"(p.3391)
Finding 96	The MCH nurse role when working with families from a refugee background: appointment scheduling
Illustration (U)	". . .sometimes it's easier to hop in the car and say 'I'm a nurse', I find a calendar and the right time. . . and then say 'interpreter' and they go 'yes'. I just find it so much easier,"(p.3391)

Finding 97	The MCH nurse role when working with families from a refugee background: Negotiating traditional versus western practices
Illustration (U)	". . .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,"[p.3392]
Finding 98	Interpreting issues
Illustration (U)	"They don't want to talk into the phone. They want to have face-to-face. P1: And you need something clearer. We've got little old phones that are not very good for those sort of things. P3: That would only work in the centre and we're often home visiting. So most interpreting goes through a family member. . .,"[p.3392]
Finding 99	Access to other referral agencies
Illustration (U)	". . .The neighbourhood House or. . . playgroup. . .I think this Baptist Church has a few programs for them as well. . .And the Salvation Army. . . they have a community garden that a lot of the men work at,. . . So there's a few different programs for different areas of the community that are set up. . .,"[p.3393]
Finding 100	Access to other referral agencies: strategies to engage with different culture
Illustration (U)	"For those of us who travelled to foreign countries, you could really relate to the anxiety and the vulnerability that you experience when you're in another culture. . . bringing that forward and becoming aware. . . can. . . help you engage. . .,"[p.3393]
Finding 101	How to identify women from a refugee background
Illustration (U)	one participant felt that probing questions were vital: ". . .it's for a reason. It's not to be nosy. It's not to be disrespectful. It's about driving the service and what's appropriate for them, and liaising, providing appropriate resources for them,"[p.3391]
Winn A, Hetherington E, Tough S. Caring for pregnant refugee women in a turbulent policy landscape: perspectives of health care professionals in Calgary, Alberta. Int J Equity Health. 2018;17(1):91.[48]	
Finding 102	Pregnant refugees are a heterogeneous population facing multiple barriers to care
Illustration (U)	"Those who come as claimants have a lot more barriers I think in Canada than you know private and government sponsored,"[p.7]
Finding 103	Health care professionals specialized in refugee health engage in diverse strategies of care
Illustration (U)	". . .So, we work closely with the social workers and they're very instrumental in helping provide supports, just resources, physical resources, but also trying to get the social supports in place to,"[p.7]
Finding 104	Health care professionals specialized in refugee health engage in diverse strategies of care: clear communication
Illustration (U)	"I always use highlighters, highlight the relevant information, and then print a navigation map, what bus you take, where do you get off. I circle everything, I'm always telling them if you are ever lost you just show this to the driver, they will know exactly where to tell you to get off. When I'm calling the agencies, I'm preparing them to make sure they know my patient doesn't speak the language. [I ask] do you have anybody in the agency who speaks that particular language, any volunteer, anybody? If not, I'm asking [the refugee], please bring your interpreter with you if you can, and I'm always trying to tell them, bring an adult interpreter. We do not want for children to be exposed to that you know, taking on the families' problems, because perhaps it becomes heavy for them,"[p.7]
Finding 105	Health care professionals specialized in refugee health engage in diverse strategies of care: coordinating the care
Illustration (U)	"We coordinate appointments, lab appointments, ultrasounds, other specialist appointments, dentist appointments, then we rebook them,"[p.7]
Finding 106	Health care professionals specialized in refugee health engage in diverse strategies of care: advocating
Illustration (U)	"I should say 75% of all my job is advocacy. Opening and pushing the doors, sending the letters, sending the fax, calling them, pushing them, leaving them messages, in order to be the speakers of those [refugees] who have no voice,"[p.8]

Finding 107	Funding cuts created a confusing system which jeopardized care
Illustration (U)	"We heavily involved like, social work to figure it out [levels of coverage], like all of the front staff, and they had to be like on the ball. And then things kept on changing [. . .] so it just made it very confusing [. . .] Yeah, so it was just constant energy, umm involved in this,"(p.8)
Finding 108	Pregnant refugees are a heterogeneous population facing multiple barriers to care: language and comprehension
Illustration (U)	"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 not 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,"(p.6)
Finding 109	Syrian influx created additional strains on existing problems
Illustration (U)	"So, we had a walk-in in clinic at the Travelodge and I was one of the [health care workers] mandated at the walk-in clinic [. . .] and if they came to me and they were prenatal, I would definitely call the clinic that day and say we need an appointment for this prenatal patient, can we fit her in? Literally fit her in. So, then we would require some rearranging of appointments, and scheduling and all that stuff, yeah, yeah, just because we wanted to confirm how far along they were and get everything kind of set up for her,"(p.9)
Finding 110	Health care professionals unfamiliar with refugee health may be overwhelmed
Illustration (U)	"Sometimes our [refugee] patients even ask us in triage like financial concerns, and I don't know what to say at all. Like that's something I would like to be more educated on, like what kind of services are available to you [refugees],"(p.10)
Finding 111	Health care professionals unfamiliar with refugee health may be overwhelmed: discerning migrant status
Illustration (U)	"I worked at urgent care [before working at the MRHC] and I don't think I even inquired [if a patient was a refugee], like I wouldn't have even known they were refugees or not,"(p.10)
Yelland J, Riggs E, Wahidi S, Fouladi F, Casey S, Szwarc J, et al. How do Australian maternity and early childhood health services identify and respond to the settlement experience and social context of refugee background families? BMC Pregnancy Childbirth. 2014;14(1):348-60.[45]	
Finding 112	Identifying and responding to social health issues: the experience of health professionals - Identification of refugee background
Illustration (U)	"I naively thought. . .it was because they all had the birth date the 1st of the 1st, I thought oh yeah I can tell. But now. . .I actually ask them, how did you come to Australia, what was your journey and find that out. And they're actually really interested that you ask. (Maternal and child health nurse)"(p.8)
Finding 113	Identifying and responding to social health issues: the experience of health professionals - Adapting mental health tools
Illustration (U)	"The Edinburgh Postnatal Depression Scale - I must admit that I don't use that . . . I ask them things like how they are feeling in their heart, I ask them are they sleeping, are they eating, do they cry a lot . . .and dads will say 'oh she cries all the time.' (Maternal and child health nurse)"(p.9)
Finding 114	Identifying and responding to social health issues: the experience of health professionals - Adapting language
Illustration (U)	"Always ask them how they are, and I've learnt to ask the questions differently now because postnatal depression is not a concept that Afghan women understand but feeling very sad and missing your family and then asking about other things. (Maternal and child health nurse)"(p.9)
Finding 115	Identifying and responding to social health issues: the experience of health professionals - Relationship building
Illustration (U)	"Well I think it's a relationship that you build, listening to them, finding out a little bit how they see things and see the world. . . So I'd say it's more the relationship that is most helpful in working with refugee families,"(p.9)

U, unequivocal
FDMN, Forcibly Displaced Myanmar National; GP, general practitioner; HP, health professional; MCH, maternal and child health; MHC, maternal health clinic; MNCH, maternal, newborn, and child health; MRHC, Mosaic Refugee Health Clinic; PHC, primary health care; PPD, postpartum depression; PTSD, post-traumatic stress disorder