ORİJİNAL ARAŞTIRMA ORIGINAL RESEARCH

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# Intercultural Awareness of Nurses Towards Refugee Women and Newborns and Its Reflections on Nursing Care: A Qualitative Study

## Hemşirelerin Mülteci Kadınlara ve Yenidoğanlara Yönelik Kültürlerarası Farkındalıkları ve Hemşirelik Bakımına Yansımaları: Nitel Bir Çalışma

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**ABSTRACT Objective:** The aim of the study to determine the experiences, feelings and thoughts of nurses who provide care for refugee women and newborns. **Material and Methods:** The study had a phenomenological design. Semi-structured interviews were conducted with 13 nurses between 9 December 2019 and 19 February 2020 working in maternity and neonatal units at a public hospital in southern Türkiye. The data were analyzed by using thematic analysis. This study was guided by the Consolidated Criteria for Reporting Qualitative Research checklist. **Results:** Three themes with related subthemes were derived from the data: (a) Problems encountered, (b) Emotions and thoughts about refugees, (c) Nursing care process. **Conclusion:** Although nurses experience different problems during the care they provide for refugees, especially in terms of hygiene, communication and nutrition, it was observed that they practice their professions without discrimination with modern nursing philosophy in the care process they provide. Nurses need more professional development in order to develop their coping skills in the problems they face while caring for refugee women and newborns. Therefore, the role of refugee health nursing and nurses as an emerging field of nursing comes to the fore. In the future, this field should be included in both undergraduate and graduate nursing education curricula.

**Keywords:** Refugees; women health; newborn; nursing

**ÖZET Amaç:** Araştırmanın amacı, mülteci kadınlara ve yenidoğanlara bakım veren hemşirelerin deneyim, duygu ve düşüncelerini belirlemektir. **Gereç ve Yöntemler:** Araştırma fenomenolojik bir desene sahiptir. 9 Aralık 2019-19 Şubat 2020 tarihleri arasında Türkiye'nin güneyinde bir kamu hastanesinde doğum ve yenidoğan ünitelerinde çalışan 13 hemşire ile yarı yapılandırılmış görüşmeler yapılmıştır. Veriler tematik analiz kullanılarak analiz edilmiştir. Bu çalışmada, "Consolidated Criteria for Reporting Qualitative Research" kontrol listesi kullanılmıştır. **Bulgular:** Verilerden ilgili alt temalara sahip 3 tema türetilmiştir: (a) Karşılaşılan sorunlar, (b) Mültecilerle ilgili duygu ve düşünceler, (c) Hemşirelik bakım süreci. **Sonuç:** Hemşireler bakım sırasında özellikle hijyen, iletişim ve beslenme sırasında farklı sorunlar yaşamalarına rağmen bakım sürecinde modern hemşirelik felsefesi ile ayrım yapmadan mesleklerini icra etmektedirler. Hemşirelerin mülteci kadınlara ve yenidoğanlara bakım verirken karşılaştıkları sorunlarla baş etme becerilerini geliştirebilmeleri için daha fazla mesleki gelişime ihtiyaçları vardır. Bu nedenle mülteci sağlığı hemşireliği, gelişmekte olan bir hemşirelik alanı olarak rolü ön plana çıkmaktadır. Gelecekte bu alan hem lisans hem de lisansüstü hemşirelik eğitimi müfredatlarına dahil edilmelidir.

**Anahtar Kelimeler:** Mülteciler; kadın sağlığı; yenidoğan; hemşirelik

Migration appears before us as an international problem in our present day.[1] According to the 2020 World Migration Report Analysis of the International Organization for Migration, the number of migrants increased to 272 million on a global scale, and reached 3.5% of the world population. Türkiye is the country that hosts the highest number of refugees in the whole world.[2] According to 2021 statistics, the number of registered Syrians who are under temporary protection is 3,656,525 people in Türkiye; and

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47.4% of these are children between the ages of 0-18; and children and women between the ages of 0-18 constitute 70.8% of the total population. There are people from other nationalities, such as Iraq, Afghanistan, Pakistan and Lebanon as well as Syrian refugees.[3] Despite their diverse cultural backgrounds and nationalities, refugees and asylum seekers often share common experiences, including trauma, the loss or separation of family members, as well as stigma, discrimination.[4]

Especially women and children are disadvantaged, vulnerable and more prone to healthcare problems in the refugee group.[5] Refugee women experience more sexual health and reproductive health-related problems, violence and gender-based inequalities and newborns and children experience problems because of unfavorable living conditions.[5,6] Vulnerable groups may encounter problems in accessing health services and may be exposed to health inequalities.[7]

Türkiye hosts the largest registered refugee population in the entire world, which makes it difficult to cover the needs of all refugee women and children in terms of protection and access to healthcare. It was stated in the report of Turkish Medical Association on War, Migration and Health that a significant number of the problems in healthcare services provided to refugees are faced in health services for women and children.[8] It was also reported that low socioeconomic status, difficulties in communication, low health literacy and many other factors might prevent refugee women and newborns from accessing healthcare.[6] However, according to the Temporary Protection Regulation that was issued in our country in October 2014, refugees were given the right to benefit from health services free of charge. Apart from healthcare staff, translators, physiologists and social workers are also active in Migrant Health Centers.[9]

Nurses play important roles as healthcare staff in helping refugees overcome barriers they face in policy and healthcare system-related care and treatment.[10,11] In this context, it is mandatory that cultural differences are considered as a central issue in nursing practices because life transitions and health behaviors are the main focus of nursing care.[12]

Cultural values influence what women understand as their role as a mother, their preferences for pregnancy and childbirth, and what is appropriate behaviour for health workers, their family members and themselves throughout pregnancy and birth.[13] However nurses have stated that beliefs and attitudes related to diseases and healthcare vary across different societies and that they may encounter problems in with patients from different cultures while providing care.[14,15] There are studies conducted to determine the problems regarding refugee patients' needs and difficulties, but the number of studies specifying the difficulties that nurses face while providing care to this group is still limited.[16,17] It is important to identify the problems, barriers and support requirements experienced by nurses who provide care for women and children who are plenty in number in the refugee population and who have greater health needs, and to provide culturally competent care. In this respect, the purpose of our study was to determine the experiences, feelings and thoughts of the nurses who provide care for refugee women and newborns.

## MATERIAL AND METHODS

### STUDY DESIGN

The study was conducted in descriptive qualitative phenomenological design. In this study, Giorgi's phenomenological research approach was used. Because it is unique that nurses care for refugee women and newborns. At the same time, this approach enables researchers to integrate nurses' experience of caring for refugee women and newborns and to define the basic structure.[18] Consolidated Criteria for Reporting Qualitative Research were used.[19]

### SAMPLING

The study was conducted between December 2019 and February 2020 with the nurses who worked in the maternity and neonatal units of a public hospital in southern Türkiye. Participants who have been nursing in the maternity and neonatal services for at least 1 year and volunteered to participate in the study were included in the study. An invitation letter was sent to 34 nurses who met the inclusion criteria of the study. During the interviews, it was accepted that the data

reached saturation when the data was repeated after the 11th interview. We continued to collect data with 2 more interviews to ensure and confirm that there were no new themes emerging, and we concluded the study with 13 nurses.[20]

## DATA COLLECTION TOOLS

The data were collected by using the sociodemographic characteristics form and semi-structured interview form, which is prepared by scanning the literature and obtaining expert opinion, were used in data collection. The sociodemographic characteristics form contains age, gender, unit was the participants worked and their working durations in the profession. In the semi-structured interview form, "what can you tell us about your experience caring for refugee women and newborns?, what does caring for refugee women and newborns mean to you?, how did you feel about your experiences of caring for refugee women and newborns?, how do your experiences with refugee women and newborns affect your care process?" main questions were used.

## DATA COLLECTION

The individual in-depth interview method was used in the collection of the data. Face-to-face individual interviews were conducted with each participant in the study area on the date/day/hour of the pre-arranged appointment. The in-depth interviews were conducted by using a voice recorder in the nurse's room, where nurses were under favorable conditions in a setting they knew and felt comfortable. To test the clarity of the questions and the suitability of the questions for the study and to experience the interview process by the researcher, 1 nurse was pilot interviewed, and her data were not included in the analyses. The mean duration of the interviews with nurses was 29.41 minutes (range 18-41 minutes).

## DATA ANALYSIS

The data were analyzed by using inductive thematic analysis. Data were analyzed following the analytical procedures outlined by Giorgi.[18] Qualitative data analysis program MAXQDA 2020 (VERBI GmbH, Berlin) was used for the analysis of the data. Firstly, the data that were collected by the researcher were deciphered for the analyses in the study. In the deciphered texts and reports, the numbers given during the interviews were used instead of the real names of the nurses. All statements from 13 participants were read through repeatedly to determine the overall feel of the data. Researchers try to maintain an objective attitude. In the next step, the decoded interviews were transferred to the MAXQDA 2020 and then the statements were re-read. Expressions thought to be important in representing nurses' experiences were decomposed into units of meaning. In the next step, while the meaning units derived to form themes were reviewed, the experiences expressed by the participants were transformed into academic descriptions. Researchers combined overlapping semantic units into a single semantic unit, and then mutually validated their results.[18] They then conducted a review to determine whether themes were embedded in each participant's statements and were combined to define the underlying structure. In this process, approximately 338 meaningful expressions, 23 academic descriptions and 3 main themes related to the experiences of the participants were obtained.

In this study, criteria (credibility, transferability, dependability and confirmability) suggested by Guba and Lincoln were applied to evaluate the reliability of the data.[21]

The methods and analyses used to ensure the dependability of the study were explained in detail. To achieve credibility of the study, member checking was carried out. The researchers independently evaluated the data to ensure the research's credibility, and participants were requested to read and confirm the transcripts. The two authors had been trained in qualitative methods. The authors had experience related to qualitative research. They attended MAXQDA qualitative data analysis course, qualitative research methods courses, and conducted qualitative studies. Confirmability was achieved by using peer review or peer debriefing performed by an expert apart from the research team members. In order to ensure data transferability, a detailed description of the sample and extensive descriptions of the data was provided. For the reliability of the study, participants were encouraged to express their opinions comfortably at the beginning of the interview. The interviews were conducted in an environment where the participants were com-

fortable, without anyone other than the researcher and the participant. During the interviews, 18-41 minutes were allowed for the participants to express themselves. In order to ensure reliability, the opinions of nurses were presented with explanatory notes.

### ETHICAL DIMENSION

The permission to conduct the study was obtained from the Burdur Mehmet Akif Ersoy University Non-Interventional Clinical Research Ethics Committee (date: February 6, 2019; no: 2019/27), the Ministry of Health, and the institution where the study was conducted. Written and verbal informed consent forms were obtained from the nurses before the study. The study was conducted in accordance with the principles of the Declaration of Helsinki.

## RESULTS

It was determined that the mean age of the nurses was 38.3±6.1 years, all nurses were female, and the average working time in their profession was 17.5±8.6 years. After the interviews conducted with nurses, 3 themes were identified, which are 1) Problems encountered, 2) Emotions and thoughts about refugees, and 3) Nursing care process. Sub-themes were included under these 3 themes that were identified in the study (Figure 1).

### THEME 1. PROBLEMS ENCOUNTERED

The problems faced by the nurses when providing care for refugee women and newborn in the clinic are given in Figure 1. Most commonly, nurses said they faced problems such as the family did not care about the child's care, there was lack of self-care, and language problems. A nurse (47 years of age, nurse 7) said *"Mothers are very incapable in providing care ... When mothers come to the hospital, they do not want to take care of their baby. They act like this maybe because their psychology is adversely affected, they are unhappy, they have no hope for their future."* Another nurse (38 years of age, nurse 8) said *"... When they come, their clothes stink, sometimes even the baby feels uncomfortable, and does not want to suck."*

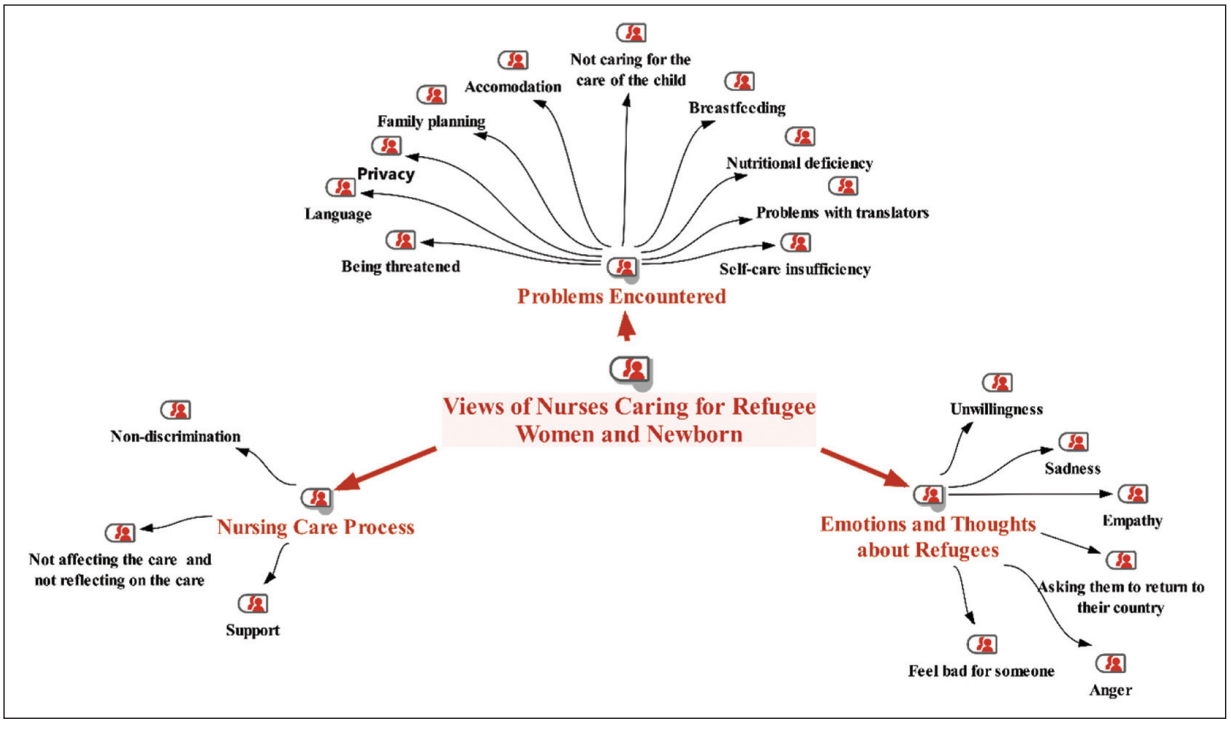


**FIGURE 1:** Themes according to the opinions of nurses who care for refugee women and newborn.

Other examples of language problems are as follows.

*"I am having trouble in providing care and expressing myself because of language. I become nervous, depressed when I do not get the return of the training I provide." (47 years of age, nurse 7).*

In addition to these, nurses who participated in the study also said that they also had problems such as malnutrition in children, breastfeeding, privacy problems, and problems with interpreters, family planning, housing, threats and parents' fear of abduction of their babies (Figure 2).

Here are some examples of the problems nurses face:

*"The hospital has interpreters, we call them, however, they are not always accessible, they have trouble coming in every minute." (42 years of age, nurse 6).*

*"They come to us with problems that are caused by nutrition ... I would not say that they are cachectic because of malnutrition; however, children who have overfeeding disorders also present, or many severe cases with upper respiratory tract infections, or babies who are not well developed in the womb because of negative pregnancy conditions brought by the mother." (44 years of age, nurse 11).*

*"They do not want to breastfeed their babies too much for nutrition, they do not want to deal with it, I see that baby food is easier for them." (35 years of age, nurse 4).*

*"We do not provide care for a single child patient, they want to spend the whole winter here in the hospital either because of the heat or because of the nutrition." (44 years of age, nurse 13).*

*"Since they think it is a sin, they do not want to use family planning as a method of protection. We provide family planning training, but I do not think it is very effective." (43 years of age, nurse 12).*

*"They say that 'You have to care for us', they say 'the state is behind us'. For example, they say 'We will call the President. They threaten us like this, to be honest." (26 years of age, nurse 5).*

*"I mean, there is a mistrust in us, they have the impression that we are going to abduct the baby, and when we hold the baby for taking blood, when we take it to the neonatal intensive care unit, the mothers follow us." (47 years of age, nurse 7).*

## THEME 2. EMOTIONS AND THOUGHTS ABOUT REFUGEES

Many of the nurses included in the study said that they felt anger towards refugees (Figure 3). One of the nurses (38 years of age, nurse 8) said; *"Many of them are unconscious, they say 'I will become pregnant again and give birth again', you become angry about them, whose country you are from, you do not*

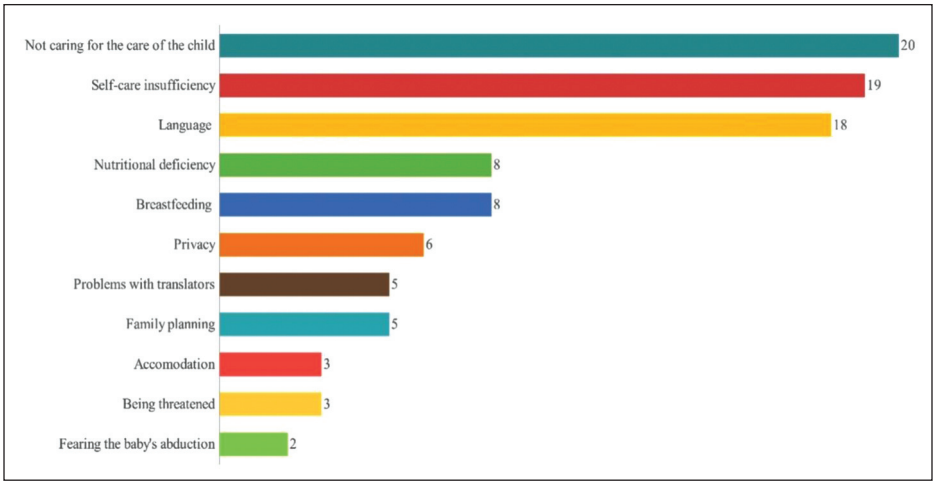


**FIGURE 2:** Problems encountered by nurses.

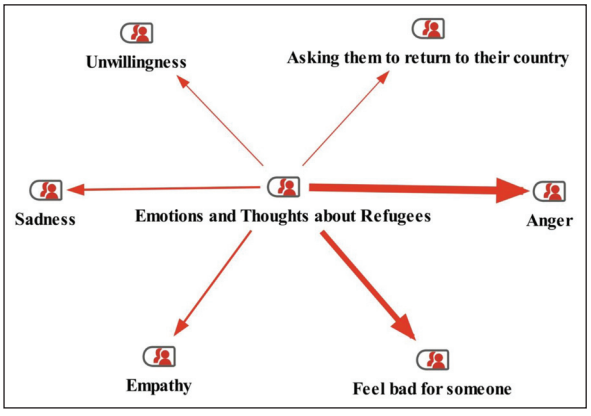


**FIGURE 3:** Feeling and thoughts of nurses about refugees.
* The thickness of the arrows reflects the frequency of expression.

*have a regular income, why do you always want to have children."*

The nurses also said that they felt pity, empathy, sadness, reluctance to care for them, aside from feeling angry, because of the problems they faced in caregiving, and wanted them to return to their home countries. A nurse (40 years old of age, nurse 10) said *"I mean let me tell you first, I pity them because they are in another country. I mean, I think of my own children when I see them like this."*

### THEME 3. NURSING CARE PROCESS

Nurses stated that no matter how they felt about refugee newborn and their families, they did not discriminate during care process, their feelings and thoughts did not affect their caregiving duty, and they did not reflect these on the care and support they provided.

Sample Expressions:

*"It does not affect my caregiving very much, because they are innocent babies. I love my job, and I am very happy to work in the neonatal unit. Frankly, they are all patients to me whether they are Syrians, Afghans, or Turks. I continue my normal duties without discriminating, without disgust or prejudice." (40 years of age, nurse 10).*

*"As I said, we try to provide them with supplies with our own wages, sometimes we use diapers leftover from other patients, we use their clothes, but there are others that do not do these." (38 years of age, nurse 8).*

## DISCUSSION

Migration is mainly a life-related transition. A refugee woman faces vital events that require physiological and psychological adaptation, such as pregnancy, childbirth and postpartum in this process. Refugee women might also face prenatal and postpartum adaptation problems, along with language barriers, racism, poverty, traditional cultural norms, and as a result, maternal mental healthcare problems.[15] In this respect, women might face attachment problems during the postpartum period. They might not want to take care of their babies, and they may not have the desire to cover their self-care needs including breastfeeding.

In the present study, nurses said that women did not take care of their children, they had inadequate self-care, and hygiene problems. It was reported in previous studies that the personal hygiene of refugee women and children was found to be inadequate.[22,23]

Women might also face depression because of the psychosocial problems they experience after migration.[24] Depending on the depression, it is considered that mothers have problems in fulfilling their self-care requirements of both themselves and their babies due to reluctance, weakness and desperation.[25] In our study, the findings that nurses stated that women were unhappy and had no hope for their future.

One of the findings of the present study was that many nurses have problems in this issue because they speak different languages with refugee patients, which is a similar finding with the literature data.[26,27] Misunderstandings that occur between refugee individuals and health professionals because of language problems can cause that patients are dissatisfied and have decreased trust in the healthcare system.[15] It is reported in previous studies that refugees cannot express themselves because of language barriers, are not understood by healthcare employees, do not apply for healthcare services, do not detect symptoms of the disease, and do not trust in healthcare employees.[28,29] It was reported in another study that refugees and their relatives did not want to follow hospital rules and even abuse healthcare employees because of language problems.[28] In our study, refugee families did

not trust in nurses, they thought that their children would be kidnapped, families threatened nurses, which is similar to the results in the literature.

Although the language barrier is an important problem when nurses provide care for refugee newborn and their families, interpreting services pose an important step to eliminate this problem. However, it is reported in the literature that the number of translators is not adequate, and translators are not available at all times, which is similar to the findings of the present study.[26,27,30] In a systematic review, nurses who work with adequate professional interpreters provide better care. It is also reported in previous studies that discharge planning, objective translation, and decision-making process are better when nurses have access to a professional interpreter.[27] In the present study, nurses said that they had difficulty in providing treatment and care because of language problems, which can reduce the quality of care.

Among the important findings of the study, there is the detection of malnutrition in children. In different studies conducted with refugee children, it was reported that there is malnutrition in refugee children; and children's growth is therefore lagging behind.[31] Malnutrition increases infection risk, frequency and severity of infections, and delay recovery in children.[32] For this reason, refugee children must be provided with breast milk and healthy nutrition after birth, which are among the most basic life rights like other children, and their growth and development must be monitored. Nurses must continue to provide advice and support to mothers about the importance of breast milk and the need for babies to receive only breast milk for the first 6 months.

Migration might affect the health of babies as well as their mothers' health. Factors that affect the general health of refugee women also affect reproductive health problems indirectly. Refugee women face various problems with pregnancy.[33] It was determined that almost all migrant women had inadequate knowledge on using family planning services, had low rates in using long-acting contraception methods, and lacked knowledge on tube ligation and emergency contraception methods.[4] According to Türkiye Demographic and Health Survey 2018 data, a Syrian migrant woman gives birth to an average of 5.3 children in Türkiye.[9] In the present study, nurses said that women did not know family planning methods, did not want to use them, and were also reluctant to participate in the training on this subject. It is recommended that nurses working in women's health increase counseling services on family planning and provide guidance on access to this service.

Since nurses are the medical staff spending the most time with patients and their families communicating with them most intensively, their feelings and thoughts towards refugees when providing care are important. Although some of the nurses who were included in our study felt anger towards refugee patients because of the increased workload and communication problems, many others expressed pity for children who were unaware of anything and tried to empathize as they were away from their homeland. In the studies reported in the literature, it was found that nurses mostly had compassionate and empathetic approaches.[34] In some other studies, nurses who wanted that refugees went to their homeland, may also have feelings of hopelessness or reluctance during providing care.[35] It was found that the personality characteristics of the medical staff also affect their feelings towards patients. However, in our study, none of the nurses reflected these feelings during caregiving and said that they cared for patients without discrimination in a professional manner without discriminating them in racial, religious or ethnic terms.

## CONCLUSION

The present study showed that nurses practice their profession with modern nursing philosophy and without discriminating against anybody although they face different emotions during the care of refugees and various difficulties in hygiene, communication, and nutrition in the treatment and care process. Women's health and pediatric nurses are the group with the greatest roles to play to protect and improve the health of refugee women and newborn, who face many healthcare problems because of migration. Nurses also need to be informed on the legal status and rights of refugees in solving the related problems, and the number of nurses and interpreters must be in-

creased. Nurses need more professional development to improve their coping skills in the face of problems they experience when they provide care. For this reason, as a newly emerging nursing field, refugee health nursing and the role of nurses come to the forefront. This must be included in undergraduate and graduate nursing education curricula in the future.

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*During this study, no financial or spiritual support was received neither from any pharmaceutical company that has a direct connection with the research subject, nor from a company that provides or produces medical instruments and materials which may negatively affect the evaluation process of this study.*

### *Conflict of Interest*

*No conflicts of interest between the authors and / or family members of the scientific and medical committee members or members of the potential conflicts of interest, counseling, expertise, working conditions, share holding and similar situations in any firm.*

### *Authorship Contributions*

*All authors contributed equally while this study preparing.*

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