Natural Resources for Human Health
eISSN: 2583-1194

Original Research

Received 25 July 2025
Revised 22 Aug 2025
Accepted 08 Sep 2025

Natural Resources for Human Health 2025, Vol. 5 (1s): 73-87

KEYWORDS:
refugees; culturally responsive nursing; trauma-informed care; health equity; cultural humility

Culturally Responsive Nursing Care for Displaced Populations and Refugees: Models of Trauma-Informed Practice and Health Equity Outcomes

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ABSTRACT: Forced displacement has reached unprecedented levels, and nurses are often the first and most continuous point of contact for refugees in host-country health systems. This narrative review examines how culturally responsive and trauma-informed nursing models can advance health equity for displaced populations. Drawing on 43 peer-reviewed and institutional sources published between 2017 and 2024, we synthesize evidence on trauma and post-migration stress, access barriers, conceptual foundations,

trauma-informed care, and intervention evidence. We propose an integrated framework linking structural determinants, nursing practice domains, and equity-relevant outcomes. Relational safety, professional interpretation, culturally grounded assessment, and scalable psychological interventions emerge as promising, although rigorous outcome evaluation remains limited. Implications for nursing practice, education, organizational policy, and future research are discussed, with emphasis on measurable equity indicators, workforce support, community partnership, and the structural conditions that shape whether displaced people can obtain safe, respectful, and effective care across diverse host-country health systems and settings.

1. INTRODUCTION

Forced displacement is one of the defining humanitarian and public health challenges of the current era. By the end of 2023, an estimated 117.3 million people worldwide had been forced to flee their homes because of persecution, conflict, violence, and human rights violations (UNHCR, 2024). Behind this figure are individuals and families who carry diverse languages, faiths, kinship structures, and understandings of illness, and who enter host-country health systems after journeys that frequently involve loss, violence, and prolonged uncertainty. The health of these populations is shaped less by an inherent vulnerability than by the conditions under which they live before, during, and after displacement, a point that is emphasized in the global assessment of refugee and migrant health produced by the World Health Organization (World Health Organization [WHO], 2022). Where host-country policies restrict access to care, housing, work, or legal security, inequities in health are produced and sustained, as the UCL–Lancet Commission on Migration and Health has argued (Abubakar et al., 2018).

Nurses occupy a distinctive position in this landscape. They are present in primary care clinics, reception centers, antenatal services, emergency departments, schools, community programs, and mental health units, and they often provide the longest and most continuous contact that a newly arrived person has with the formal health system. The quality of that contact matters. A nurse who is able to create safety, communicate across language, understand the meaning of symptoms within a cultural frame, and recognize the possible imprint of trauma can change whether a patient returns for care, discloses a concern, or understands a treatment plan. Conversely, rushed, culturally uninformed, or inadvertently coercive encounters can deepen mistrust and compound earlier harm.

Two bodies of thinking have been central to efforts to improve nursing care in these circumstances. The first is the family of approaches variously labeled cultural competence, cultural humility, and cultural safety, which concern how clinicians understand difference, power, and the patient's own frame of reference. The second is trauma-informed care, which concerns how services recognize the widespread impact of trauma and organize themselves to avoid re-traumatization. These traditions developed in different fields and are sometimes presented as separate, yet in the care of refugees they are practically inseparable: trauma is always experienced, expressed, and interpreted through culture, and culturally responsive care that ignores trauma will frequently miss what matters most to the patient.

Despite widespread endorsement of both traditions, the literature on their integration in nursing is dispersed across mental health, maternal health, public health, and nursing education journals, and there is little synthesis that connects models of practice to equity-oriented outcomes. This narrative review addresses that gap. It asks three questions: (a) what do we know about the trauma burden and structural barriers that shape the health of displaced populations; (b) which conceptual and practice models can guide culturally responsive and trauma-informed nursing; and (c) what does the available evidence suggest about their contribution to health equity? The review concludes with an integrated framework intended to support practice, education, and research.

2. METHODS

2.1 Review design

A narrative review design was selected because the topic spans conceptual models, qualitative service evaluations, intervention trials, and policy reports that cannot be meaningfully pooled statistically. Narrative reviews are well suited to integrating heterogeneous bodies of knowledge and to developing conceptual frameworks, provided that the process is transparent and the interpretation is disciplined (Greenhalgh et al., 2018). To promote rigor, the review was guided by the six quality domains

of the Scale for the Assessment of Narrative Review Articles, namely justification of the article's importance, a statement of aims, a description of the literature search, referencing, scientific reasoning, and appropriate presentation of data (Baethge et al., 2019).

2.2 Literature identification and selection

The literature was identified through structured searches of nursing, public health, psychology, and migration-studies sources, supplemented by citation tracking from key reviews and reports. Search concepts combined terms for displaced populations (refugee, asylum seeker, forced migrant, humanitarian migrant), nursing and health care (nurse, nursing, primary care, midwifery), cultural approaches (cultural competence, cultural humility, cultural safety, culturally responsive), trauma approaches (trauma-informed, trauma-sensitive, psychosocial), and equity (health equity, disparities, access). Sources were included if they were published between 2017 and 2024, were available in English, and addressed refugees, asylum seekers, or other forcibly displaced groups, or provided conceptual or empirical foundations directly applicable to their care. Systematic reviews, meta-analyses, randomized trials, qualitative studies, conceptual papers, and major institutional reports were eligible. Sources were prioritized where they offered the strongest available evidence on a given question, represented diverse settings, or articulated models relevant to nursing practice. Forty-three sources were ultimately retained for synthesis.

2.3 Synthesis approach

Retained sources were read in full and organized thematically around the three guiding questions. Conceptual models were compared in terms of their premises, their implications for nursing action, and their documented limitations. Empirical studies were appraised for design, population, and applicability, with greater interpretive weight given to systematic reviews and trials. Because no formal risk-of-bias scoring was applied, conclusions are presented as an interpretive synthesis rather than as a quantitative estimate of effect, and the limitations section addresses the consequences of this choice.

3. DISPLACEMENT, TRAUMA, AND HEALTH INEQUITIES

3.1 The burden of trauma and mental ill health

Refugees and asylum seekers experience elevated rates of common mental disorders. A large systematic review and meta-analysis reported high prevalence estimates for post-traumatic stress disorder and depression among refugees and asylum seekers, with substantial heterogeneity across studies, settings, and measurement methods (Blackmore et al., 2020). A subsequent meta-analysis of studies in high-, middle-, and low-income host countries similarly found substantial prevalence of post-traumatic stress, depression, and anxiety, and emphasized that estimates vary with sampling and assessment instruments (Patanè et al., 2022). Evidence from conflict-affected populations more broadly indicates that mental disorders are considerably more common than in general populations, a finding that has direct implications for service planning in both humanitarian and resettlement contexts (Charlson et al., 2019).

It is important not to read these estimates as evidence that displacement automatically produces psychopathology. The variability across studies points to the influence of context, and the nursing implication is that distress should be understood in light of what is happening to people now as well as what happened to them before. A critical review of the post-migration literature concluded that social determinants in the resettlement setting, including insecure legal status, unemployment, poverty, discrimination, loneliness, and poor housing, are strongly associated with refugee mental health, and in many studies account for variance beyond that explained by pre-migration trauma (Hynie, 2018). Cohort evidence from Australia reached a consistent conclusion, showing that pre-migration trauma and post-migration stressors both contribute to mental health problems and that post-migration difficulties can intensify the effects of earlier trauma (Chen et al., 2017). These findings matter for nursing because many post-migration stressors can be recognized and sometimes mitigated at the point of care, through referral, advocacy, and coordination, rather than being treated as background circumstances that lie beyond the nurse's reach.

Figure 1 summarizes this cumulative exposure model and identifies the points at which nursing practice can intervene. It is not intended as a deterministic pathway. Many displaced people show remarkable resilience, and the same experiences may produce different responses depending on the availability of safety, social support, and meaningful roles. The model's purpose is to direct nursing attention to modifiable conditions and to emphasize that assessment should encompass the whole trajectory of displacement.

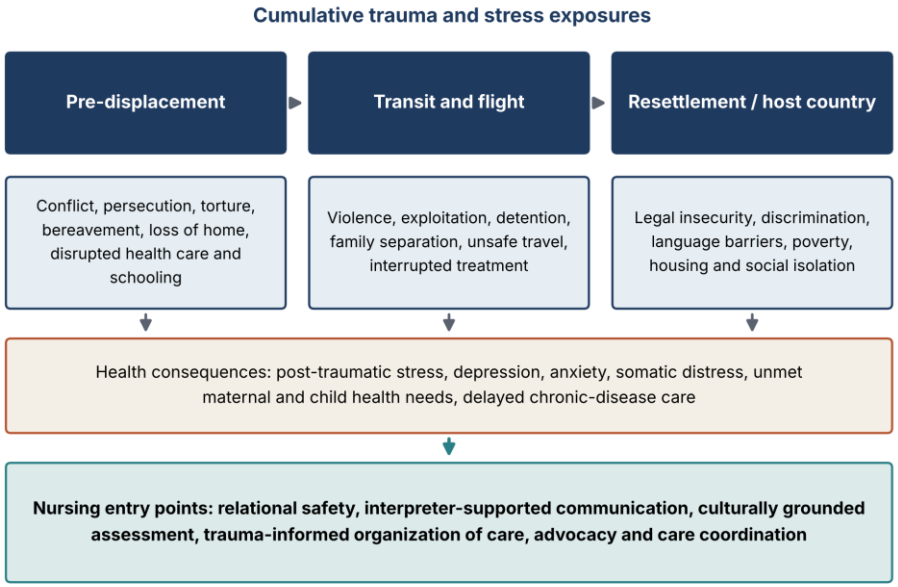

Figure 1. Cumulative trauma and stress exposures across the displacement trajectory and corresponding nursing entry points.

3.2 Barriers to access and quality of care

Trauma exposure is only one dimension of inequity. A scoping review of refugees' experiences of health care in host countries identified recurring themes of language barriers, unfamiliarity with the health system, long waiting times, and feeling disrespected or unheard, alongside positive experiences when providers showed empathy and took time to listen (Mangrio & Sjögren Forss, 2017). A systematic review of challenges in delivering care to migrants and refugees in high-income countries organized barriers into a three-part model concerning communication, continuity of care, and concepts of illness, showing that misunderstandings arise not only from language but also from divergent explanatory models and from care that is fragmented across providers and settings (Brandenberger et al., 2019).

Service providers who work with refugees report that the barriers to mental health care are structural as well as cultural. A Canadian study of immigrant service providers described limited availability of interpreters, stigma surrounding mental illness, lack of culturally appropriate services, and the complexity of navigating systems as key obstacles to access and use (Salami et al., 2019). Discrimination operates as a further structural barrier; research with people from refugee and asylum-seeking backgrounds resettled in Australia documented that experiences of discrimination were associated with poorer health and that these experiences occurred in employment, housing, and everyday encounters as well as in services (Ziersch et al., 2020). For nurses, the implication is that culturally responsive practice cannot be confined to individual encounters. It must also address the conditions that make encounters inequitable before they begin.

Interpretation is a particularly consequential issue. Qualitative research on mental health service provision with refugee clients has shown that interpreters can function as an invisible bridge or as a source of disruption, depending on whether clinicians prepare for the interpreted session, attend to the triadic relationship, and recognize the interpreter as a participant in the clinical interaction (Gartley & Due, 2017). Ad hoc interpreting by family members, children, or bilingual staff without training introduces risks of omission, distortion, and breaches of confidentiality, and may prevent disclosure of sensitive material such as sexual violence or domestic abuse.

3.3 Maternal and child health

Maternity care provides a clear illustration of how inequities arise at the intersection of trauma, culture, and system design. A systematic review of systematic reviews found that asylum-seeking and refugee women are at increased risk of adverse perinatal outcomes and often receive suboptimal care, with barriers including language, poor communication, and limited entitlement to services (Heslehurst et al., 2018). Research with allophone migrant women in maternity services highlighted that communication barriers affect women, health professionals, and intercultural interpreters alike, and that inadequate communication undermines

informed decision making and trust (Origlia Ikhilor et al., 2019). For nurses and midwives, these findings underscore that language access is a clinical safety issue rather than an administrative courtesy.

Children and families are affected through multiple, interacting pathways. A longitudinal cohort study of refugee families in Australia found that parental post-traumatic stress was associated with children's mental health difficulties, with parenting and family functioning mediating part of that association (Bryant et al., 2018). A review of preventive mental health interventions for refugee children and adolescents in high-income settings noted that school-based and family-oriented programs show promise but that the evidence base remains limited and that interventions must address the daily stressors of resettlement as well as past trauma (Fazel & Betancourt, 2018). These findings reinforce the importance of family-centered models in which nurses attend to caregivers' wellbeing as an element of child health.

4. CONCEPTUAL FOUNDATIONS FOR CULTURALLY RESPONSIVE NURSING

4.1 From cultural competence to humility, safety, and competemility

The concept of cultural competence has long guided nursing education, and it has been valuable in drawing attention to the need for knowledge, skills, and attitudes appropriate to diverse populations. Over time, however, it has attracted criticism for implying that culture can be mastered as a body of facts, for risking the stereotyping of patients by group membership, and for leaving unexamined the power relations embedded in health care. Table 1 compares the principal frameworks that have emerged in response to these critiques and indicates what each contributes to the care of displaced populations.

Table 1. Conceptual frameworks relevant to culturally responsive nursing care of displaced populations

Framework	Core premise	Contribution to refugee nursing care	Cautions
Cultural competemility (Campinha-Bacote, 2019)	Competence and humility are complementary; humility grounds the responsible use of knowledge and skills.	Encourages combining knowledge of refugee health issues (e.g., effects of torture, asylum processes) with openness to the individual.	Risk of becoming a checklist if reflection is not sustained.
Cultural humility (Lekas et al., 2020; Greene-Moton & Minkler, 2020)	Lifelong self-reflection, openness to learning from the patient, and attention to power imbalances.	Supports asking rather than assuming; reduces stereotyping; fosters partnership.	Can be interpreted as an individual attitude, overlooking institutional barriers.
Cultural safety (Curtis et al., 2019)	Safety is defined by the recipient of care; unsafe practice is linked to inequity and power.	Orients nursing evaluation toward patient experience and toward systemic change.	Originates in indigenous health; adaptation to refugee contexts needs care.
Cultural competence in refugee services (Lau & Rodgers, 2021)	Scoping of how competence is defined, taught, and evaluated in refugee-serving settings.	Identifies gaps between training, organizational support, and measured outcomes.	Definitions and measures vary widely; outcome evidence limited.
Trauma-informed care (see Section 4.2)	Recognizes the prevalence and impact of trauma; avoids re-traumatization; centers safety and collaboration.	Guides routines such as explaining procedures, offering choice, and avoiding coercion.	Often misunderstood as technique; needs adaptation to political violence and displacement.

Cultural humility reframes the task as a lifelong process of self-reflection and self-critique, openness to the patient as the expert on their own experience, and attention to power imbalances. Cultural safety, which originated in indigenous health in Aotearoa New Zealand, goes further by locating the judgment of safety with the recipient of care and by explicitly linking culturally unsafe practice to inequity. Cultural competemility, a more recent proposal, argues that competence and humility are not alternatives but complementary: humility is the foundation on which skills and knowledge are responsibly applied. Each of these has implications for refugee care. Humility encourages the nurse to ask, rather than assume, what a symptom, a family arrangement, or a refusal means. Safety directs attention to whether the patient experienced the encounter as respectful and non-threatening.

Competemility reminds nurses that humility does not excuse a lack of knowledge about, for example, the health consequences of torture or the legal context of asylum.

Two further perspectives are essential in work with displaced people. The first is intersectionality, which holds that gender, ethnicity, religion, age, sexuality, disability, and migration status interact to shape both exposure to harm and access to care; a nurse who attends only to nationality or religion will miss differences between, for example, an unaccompanied adolescent, an older widow, and a man who was detained. The second is structural competency, which expands the clinical gaze from the individual to the institutions, policies, and economic arrangements that produce illness. Both perspectives caution against interpreting health problems as the product of culture alone.

4.2 Trauma-informed care

Trauma-informed care begins from the recognition that trauma is common, that it affects how people engage with services, and that services can either retraumatize or support recovery. A conceptual analysis of relational practice described trauma-informed approaches as a paradigm shift in which the central question moves from what is wrong with a person to what has happened to them, and in which the relationship between worker and service user becomes the primary vehicle of safety, trust, and collaboration (Sweeney et al., 2018). The same authors and others have cautioned that the term is often used loosely and that trauma-informed care risks being misunderstood as a set of techniques, a trauma-specific therapy, or a universal screening requirement rather than as an organizational and relational stance (Sweeney & Taggart, 2018).

The principles most commonly invoked in trauma-informed models include safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and responsiveness to cultural, historical, and gender issues. The final principle is where trauma-informed care and culturally responsive care converge, and where adaptation for refugees is most needed. Standard formulations were developed largely in contexts of domestic violence, childhood adversity, and mental health services in high-income countries, and they do not automatically address the specific features of refugee trauma, which may include collective and political violence, torture, loss of community, and ongoing insecurity.

4.3 An integrated conceptual position

Taken together, these literatures support an integrated position that treats cultural humility and relational safety as the shared core of practice, and that treats trauma awareness and structural awareness as the two lenses through which that core is applied. Figure 2 presents this position as a set of six domains organized around that core. The model is a synthesis intended to guide practice and education. It is derived from the conceptual literature reviewed here and has not been empirically validated as a single construct, a limitation discussed below.



Figure 2. Integrated model of culturally responsive, trauma-informed nursing care for displaced populations.

5. MODELS OF TRAUMA-INFORMED, CULTURALLY RESPONSIVE NURSING PRACTICE

5.1 Organizational models in nursing settings

Nursing has a growing literature on translating trauma-informed principles into routine care. A practice development process in an acute inpatient mental health unit described how trauma-informed care was adopted as a nursing model of care, involving reflection on existing routines, reduction of coercive practices, collaborative engagement with consumers, and staff learning, and it reported perceived benefits for the therapeutic environment (Isobel & Edwards, 2017). Although that work was not specific to refugees, it demonstrates that trauma-informed principles can be operationalized at the level of ward culture and nursing routines, an insight that is directly transferable to refugee clinics, reception centers, and antenatal services.

A systematic review of trauma-informed interventions provides a cautionary counterpoint. It found that trauma-informed interventions have been implemented across many settings and populations and are associated with improvements in some mental health outcomes, but that the quality of evidence is uneven, definitions vary, and few studies use rigorous designs or measure organizational change (Han et al., 2021). This implies that nurses and managers who adopt trauma-informed models should do so with attention to evaluation, rather than assuming that adoption in itself guarantees benefit.

5.2 Integrating cultural humility with trauma-informed care

The most direct treatment of integration in the nursing and mental health literature is the argument that trauma-informed care and cultural humility are mutually reinforcing and that neither is adequate for minoritized communities on its own. This work contends that trauma-informed care risks reproducing harm if it ignores historical and structural oppression and the cultural meanings of distress, while cultural humility without trauma awareness risks overlooking how violence shapes engagement with care (Ranjbar et al., 2020). The authors offer practical illustrations, such as asking about preferences for how trauma-related topics are discussed, recognizing that certain questions may be experienced as intrusive or shaming, and acknowledging the clinician's own position of power.

Research that is specific to refugee settings points in the same direction. A qualitative study of professionals serving refugees in the United States, concerned with culturally responsive trauma-informed care in the resettlement process, identified the need for staff training, interpreter availability, culturally adapted communication, attention to the daily stressors of resettlement, and organizational support for staff who work with traumatized clients (Im & Swan, 2021). Such findings are valuable because they come from practitioners who face the realities of limited resources and complex client needs, and because they stress the organizational dimension that is easily neglected when models are described only at the level of the individual clinician.

5.3 The role of education and reflective practice

Models of practice are only as effective as the workforce that enacts them. A discussion of strategies to promote cultural humility among future nursing faculty emphasized the role of faculty development, reflective exercises, immersion and community engagement, and the modeling of humility in teaching, noting that nursing educators set the tone for how students understand difference and power (Hughes et al., 2020). For education about refugee health, this suggests that curricula should move beyond cultural fact sheets toward reflective practice, case-based learning with refugee community partners, supervised practice with interpreters, and explicit teaching about trauma, asylum systems, and structural determinants.

Educators and clinical leaders should also model the practice of asking. Practical expressions of humility include inviting patients to explain their understanding of a problem, checking how much information they wish to receive and from whom, offering a choice of the gender of the clinician where possible, and being transparent about the purpose of questions and about who will see the information recorded. Such practices cost little but communicate respect, and they reduce the likelihood of an encounter replicating the interrogative dynamics that many asylum seekers have experienced in border and legal processes.

A practical example illustrates the integration. Consider a woman who has recently arrived with her children and attends an antenatal clinic. A nurse working from this model would book an interpreter in advance, explain who will be present and why each question is asked, and ask about preferences regarding the gender of the clinician. She would not press for details of past violence but would offer information about available support and make clear that the woman can raise concerns at any time. She would ask about housing, income, and legal status because these shape the pregnancy as much as clinical history does, and would link the woman with community and legal services. Each action is modest, yet together they create the conditions for trust and continuity that underpin better outcomes.

6. CLINICAL APPLICATIONS: ASSESSMENT, COMMUNICATION, AND INTERVENTION

6.1 Culturally grounded assessment of trauma and distress

Assessment is a domain in which cultural responsiveness and trauma-informed practice intersect most visibly. A review of assessing trauma in a transcultural context concluded that standard diagnostic instruments and categories may not capture culturally specific idioms of distress, that translation of instruments does not guarantee conceptual equivalence, and that clinicians must be cautious about both over-pathologizing normal responses to extreme adversity and overlooking distress that is expressed somatically or spiritually (Wylie et al., 2018). A nursing assessment that relies solely on a checklist administered through an interpreter may therefore be inaccurate, as well as unsettling for the patient.

The Cultural Formulation Interview, introduced in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, is one structured way of eliciting the patient's own account of problems, causes, supports, and preferences for help. A recent update describes its development, its field testing, and its use across settings, and presents it as a means of making cultural information central to assessment and treatment planning rather than a supplementary consideration (Jarvis et al., 2020). Although the interview was designed for mental health clinicians, its open-ended questions about how the person understands the problem, what they believe has caused it, and what kind of help they seek can be adapted by nurses in primary care and community settings.

Screening raises additional issues. A comprehensive review of the assessment and intervention literature for refugees and asylum seekers emphasized that clinicians should combine attention to trauma history with attention to current stressors, that screening is most useful when linked to accessible follow-up, and that assessment should be conducted in a stepped, relationally safe manner rather than through an exhaustive trauma inquiry at first contact (Kronick, 2018). In trauma-informed practice, nurses are not required to elicit detailed accounts of traumatic events in order to provide good care; they are required to create conditions in which the patient can choose to disclose, to respond compassionately when they do, and to ensure that what is disclosed leads to appropriate support.

6.2 Communication and interpretation

Effective communication underlies every other element of culturally responsive care. Practical nursing standards include the use of qualified interpreters, preferably with training in health or mental health interpreting, for all substantive clinical encounters; briefing the interpreter in advance; addressing the patient rather than the interpreter; allowing additional time; avoiding the use of children as interpreters; and checking understanding through teach-back. Where telephone or video interpretation is used, nurses should ensure privacy and technical adequacy. The qualitative evidence discussed earlier indicates that these practices are not merely procedural: they shape whether patients feel they are being heard and whether sensitive disclosures are possible.

Beyond language, communication includes attention to health literacy, to the meaning of silence, eye contact, touch, and modesty, and to the implications of the physical environment. Examinations may be experienced as frightening for patients who have been tortured or sexually assaulted, and routine procedures such as undressing, being restrained, or being left alone in a locked room can trigger distress. Trauma-informed nursing therefore includes explaining each step before it occurs, seeking permission, offering the ability to pause or stop, and ensuring that chaperones are acceptable to the patient.

6.3 Evidence on interventions

A range of interventions have been evaluated for refugee populations, and the evidence is summarized in Table 2. The table is organized by function in the care pathway rather than by profession, because many of these interventions are delivered by multidisciplinary teams in which nurses may screen, deliver brief interventions, coordinate care, and provide continuity. Taken together, the evidence suggests that culturally adapted screening is feasible, that trauma-focused psychological therapies and psychosocial interventions can reduce symptoms, that scalable lay-delivered approaches are promising in low-resource and humanitarian contexts, and that language access is a precondition for all of them.

Table 2. Selected evidence on interventions supporting culturally responsive, trauma-informed care for refugees

Function in care pathway	Intervention and evidence	Implications for nursing and equity
Screening and identification	The Refugee Health Screener was evaluated for efficient identification of mental health problems among refugees in Germany (Kaltenbach et al., 2017).	Brief, culturally adapted screening is feasible in routine settings; value depends on linked follow-up and interpreter support.
Language access	Qualitative evidence shows interpreters shape the therapeutic relationship, and preparation and collaboration influence the quality of interpreted care (see Section 3.2).	Qualified interpreters should be standard; training for both nurses and interpreters promotes safe disclosure and equitable access.
Psychosocial and trauma-focused therapy	A systematic review and meta-analysis of psychosocial interventions for PTSD in resettled refugees reported benefits for trauma-focused approaches (Nosè et al., 2017); another meta-analysis of psychological interventions reached broadly consistent conclusions (Thompson et al., 2018).	Nurses can facilitate referral and engagement; reducing stigma and logistic barriers helps ensure that benefit reaches those in need.
Scalable, lay-delivered interventions	A cluster randomized trial of guided self-help reduced psychological distress among South Sudanese refugee women in Uganda (Tol et al., 2020).	Task-sharing models extend reach in low-resource settings; nurses may supervise or support delivery.
Health-system strengthening	A multi-country program integrated scalable psychological interventions into care for Syrian refugees in Europe and the Middle East (Sijbrandij et al., 2017).	Demonstrates feasibility of stepped care; equity requires attention to implementation in different health systems.

Several cautions apply to the interpretation of this evidence. Trials of psychological interventions for refugees often have heterogeneous populations, short follow-up, and limited reporting of cultural adaptation. Effects reported in research settings may not translate into routine practice where staff are overstretched and where participants face ongoing insecurity. Moreover, almost all interventions listed target symptom reduction. Few studies assess whether they reduce inequities in access or outcomes between refugees and other groups, which is the question that matters most from an equity perspective. Nurses should therefore see these interventions as components of a broader approach rather than as substitutes for attention to structural determinants.

Continuity deserves particular emphasis. Refugees are often moved between accommodation sites, health districts, and even countries, and each transition risks interrupting treatment and repeating the telling of painful histories. Nurses can reduce this burden by maintaining portable records where permitted, by communicating clearly with receiving services, and by ensuring that the patient understands how to access care in the new location. Where nurses have a role in reception or transit settings, even brief encounters should be conducted so that they leave the person better informed, treated with dignity, and aware of where to seek help.

7. HEALTH EQUITY OUTCOMES

7.1 Defining equity in the context of displacement

Health equity has been defined as the principle that everyone should have a fair and just opportunity to be as healthy as possible, which requires removing obstacles to health such as poverty and discrimination and their consequences, including powerlessness and lack of access to good jobs, education, housing, and health care (Braveman et al., 2018). Applied to displaced people, this definition has two implications. First, it directs attention to differences that are avoidable and unjust, such as those created by restricted entitlements, discriminatory practices, or the absence of interpreters. Second, it implies that success should be assessed in terms of closing gaps rather than merely improving average outcomes, since averages can hide persistent disparities.

Intersectionality sharpens this perspective. An analysis of why intersectionality matters to global health argued that interlocking systems of power shape health opportunities and that equity-oriented research must examine how social positions combine rather than treat categories as separate variables (Kapilashrami & Hankivsky, 2018). For nursing, this suggests that equity monitoring should disaggregate data not only by migration status but also by gender, age, language, and other axes, and that services should look for groups that fall through gaps, such as women in remote reception settings, older refugees, people with disabilities, and unaccompanied minors.

7.2 A logic model linking nursing practice to equity outcomes

Figure 3 presents a logic model that connects structural determinants, nursing practice, proximal outcomes, and equity-relevant outcomes, with a feedback loop for monitoring. The model distinguishes between proximal outcomes that nursing can influence relatively directly, such as trust, engagement, accurate assessment, comprehension, and continuity, and distal equity outcomes that depend also on policy and the wider environment. This distinction is important because the available evidence is much stronger for the proximal level than for the distal. Culturally responsive and trauma-informed practice is plausibly associated with better engagement and experience, and these are in turn plausible mediators of improved health, but the full causal chain has rarely been tested in a single study.

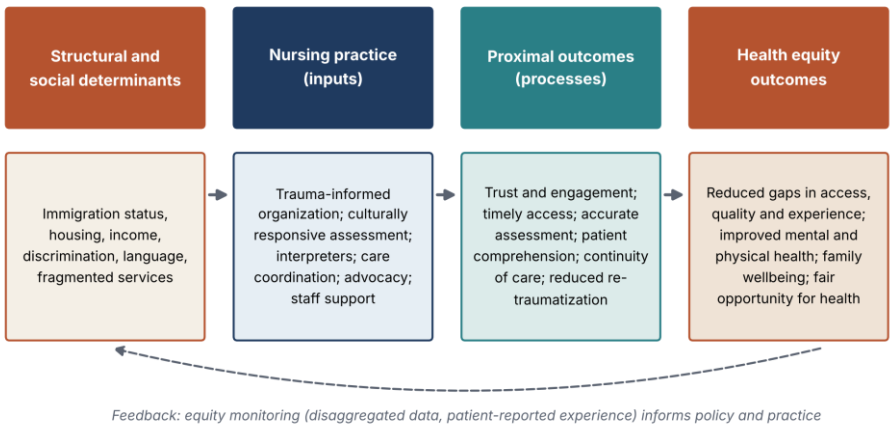

Figure 3. Logic model linking structural determinants, nursing practice, proximal outcomes, and health equity outcomes.

7.3 What outcomes should be measured?

A meaningful equity agenda requires indicators beyond symptom scores. Process indicators might include the proportion of encounters with qualified interpretation, the time to first appointment after arrival, rates of missed appointments and their reasons, and completion of screening and follow-up. Experience indicators might include patient-reported feeling of safety, respect, and being understood. Outcome indicators might include perinatal outcomes, immunization coverage, control of chronic disease, mental health symptoms, and functioning, each disaggregated by relevant social categories. Organizational indicators might include staff training coverage, availability of reflective supervision, and the presence of mechanisms for refugee community feedback.

It is also important to attend to outcomes that matter to displaced people themselves. Participatory approaches, in which refugee community members help to define success, can reveal priorities that differ from clinicians' assumptions, such as stable housing, family reunification, the ability to work, or participation in community life. Nursing evaluation that incorporates these priorities is more likely to be seen as legitimate and more likely to identify the structural determinants that shape health.

8. ORGANIZATIONAL AND WORKFORCE CONSIDERATIONS

Delivering culturally responsive, trauma-informed care at scale depends on organizational conditions. Services need predictable access to interpreters, appointment lengths that allow for interpreted consultations, flexible scheduling that recognizes the constraints of asylum procedures and transport, and referral pathways to mental health, legal, and social services. Without such conditions, nurses may be asked to practice humility and compassion within systems that structurally prevent it. Organizational

trauma-informed models stress that policies, physical environments, and procedures, as well as individual attitudes, must be reviewed for their potential to retraumatize.

Workforce wellbeing is a further requirement. Nurses who work with traumatized populations are exposed to distressing narratives and to the moral stress of working within systems that limit what they can offer. A review of the literature on vicarious trauma emphasized that its terminology and conceptualization are inconsistent but that it refers to profound changes in a helper's worldview and wellbeing arising from empathic engagement with trauma survivors, and that organizational and personal factors influence its development (Branson, 2019). Reflective supervision, caseload management, peer support, and an organizational culture that recognizes the emotional work of care are essential parts of a trauma-informed system, since the care of staff and the care of patients are intertwined.

Finally, a structural orientation needs to be built into professional development. A curriculum on structural competency for medical students, residents, and interprofessional teams, designed to teach the structural factors that produce health disparities, offers a model that can be adapted for nursing: it trains clinicians to recognize how institutions, policies, and economic arrangements shape illness, to rearticulate clinical presentations in structural terms, and to engage in advocacy and collaboration beyond the clinic (Neff et al., 2020). For nurses working with refugees, this orientation supports advocacy for entitlements, collaboration with legal and housing services, and engagement in policy processes that shape the conditions of care.

9. IMPLICATIONS

9.1 Implications for practice

For clinical practice, the synthesis supports several priorities. Nurses should treat language access as a core component of safe care and should refuse to normalize the use of untrained ad hoc interpreters. They should adopt a stance of cultural humility that begins with curiosity about the patient's explanatory model and preferences. They should organize encounters to maximize predictability, control, and dignity, and they should avoid requiring detailed trauma disclosure as a condition of care while remaining ready to respond when disclosure occurs. They should assess current stressors alongside trauma history, use culturally appropriate screening linked to follow-up, and engage in advocacy and coordination to address the social determinants that most influence wellbeing.

9.2 Implications for education and organizations

Education should integrate cultural humility, trauma-informed principles, and structural analysis within undergraduate and postgraduate curricula and should involve refugee community members as teachers and partners. Organizations should invest in interpreter services, in trauma-informed policies and physical environments, in reflective supervision, and in routine equity monitoring. Leaders should recognize that the adoption of trauma-informed language without material changes in staffing, time, and procedures is unlikely to improve care. Partnerships with community organizations, including refugee-led groups, can extend reach and build trust.

9.3 Implications for policy and research

At the policy level, nursing organizations have a role in advocating for universal entitlement to essential health care, for funded interpreter provision, and for the removal of structural barriers such as fear of reporting to immigration authorities. In research, the field needs studies that evaluate integrated culturally responsive and trauma-informed nursing models using designs that can assess implementation and equity outcomes, including hybrid effectiveness-implementation trials, stepped-wedge designs, and mixed-methods evaluations with refugee communities as partners. Measures of cultural humility, relational safety, and trauma-informed organizational practice that have been validated for refugee-serving settings are needed. Evidence is also required on subgroups such as older refugees, LGBTQ+ refugees, people with disabilities, and those in prolonged displacement in low- and middle-income countries, where most displaced people live yet where nursing research is sparse.

10. LIMITATIONS

This review has several limitations. As a narrative review, it did not follow a protocol registered in advance, did not search every database exhaustively, and did not apply formal risk-of-bias assessment. The selection of sources was necessarily judgment-based and limited to English-language publications from 2017 to 2024, which may exclude important earlier foundations and non-English literature. The tight restriction on the number of sources means that many relevant studies could not be cited. The

integrated framework is a conceptual synthesis and has not been empirically validated. Finally, the literature is dominated by research from high-income countries, and its applicability to refugee-hosting contexts in low- and middle-income countries must be considered carefully. These limitations suggest that the conclusions should be regarded as a structured interpretation of the literature rather than as definitive findings, and readers are encouraged to verify cited material in the original sources before relying on it in formal publications.

11. CONCLUSION

Nurses are central to whether displaced people experience health systems as safe, respectful, and effective. The literature reviewed here indicates that the burden of trauma among refugees is considerable but that it is inseparable from post-migration conditions that nurses and health systems can influence. Culturally responsive and trauma-informed approaches are complementary, and their integration around relational safety and cultural humility offers a coherent foundation for practice. Promising elements include professionally interpreted communication, culturally grounded assessment, trauma-sensitive routines, scalable psychological interventions, and organizational support for staff. The evidence that these elements improve health equity, as distinct from individual symptoms or satisfaction, is still thin, and building it is a priority. Realizing equity will require nursing to combine compassionate individual care with structural awareness, advocacy, and sustained investment in the systems and workforce that make such care possible.

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Natural Resources for Human Health
eISSN: 2583-1194

الرعاية التمريضية المستجيبة ثقافيًا للسكان النازحين واللاجئين: نماذج الممارسة المراعية للصدمات ونواتج الإنصاف الصحي

الملخص

بلغ النزوح القسري مستويات غير مسبوقة، وغالبًا ما يكون التمريض أول نقطة اتصال وأكثرها استمرارية للاجئين في الأنظمة الصحية للبلدان المضيفة. وتبحث هذه المراجعة السردية في كيفية إسهام نماذج التمريض المستجيبة ثقافيًا والمراعية للصدمات في تعزيز الإنصاف الصحي للسكان النازحين. واستنادًا إلى 43 مصدرًا محكّمًا ومؤسسيًا نُشرت بين عامي 2017 و2024، نُجمّع الأدلة حول الصدمة والضغط بعد الهجرة، وحواجز الوصول، والأسس المفاهيمية، والرعاية المراعية للصدمات، وأدلة التدخلات. ونقترح إطارًا متكاملًا يربط المحددات البنيوية، ومجالات الممارسة التمريضية، والنواتج ذات الصلة بالإنصاف. وتبرز السلامة العلائقية، والترجمة الفورية المهنية، والتقييم المرتكز ثقافيًا، والتدخلات النفسية القابلة للتوسّع بوصفها خيارات واعدة، وإن ظلّ التقييم الصارم للنواتج محدودًا. وتُناقَش الآثار المترتبة على الممارسة التمريضية والتعليم والسياسات التنظيمية والبحث المستقبلي، مع التأكيد على مؤشرات الإنصاف القابلة للقياس، ودعم القوى العاملة، والشراكة المجتمعية، والظروف البنيوية التي تحدّد ما إذا كان النازحون قادرين على الحصول على رعاية آمنة ومحترمة وفعّالة عبر مختلف الأنظمة الصحية والبيئات في البلدان المضيفة.

الكلمات المفتاحية :اللاجئون؛ التمريض المستجيب ثقافيًا؛ الرعاية المراعية للصدمات؛ الإنصاف الصحي؛ التواضع الثقافي.