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SPECIAL FEATURES - LAW AND ETHICS

Public health nurses' encounters with undocumented migrant mothers and children

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Abstract

Objectives: Undocumented migrant children (UMC) are often affected by policies and practices that do not take their best interests into account. The aim of this study was to describe how public health nurses (PHNs) experienced challenges and dilemmas in ensuring the best interests of the undocumented migrant child.

Design: This study had a qualitative descriptive design.

Sample: Focus group interviews and semi-structured interviews were conducted with seven PHNs in four different child health centers (CHCs).

Results: Qualitative content analysis was applied. Three main themes were identified: building trust, ensuring the best interests of the child, and dilemmas and challenges in ensuring the best interests of the child. The study revealed examples of immigration policy being prioritized over the best interests of the child. PHNs experienced frustration when the best interests of the child were not taken into account. Strategies for managing these conflicting demands were identified.

Conclusion: Conflicting demands appeared when national immigration policies collided with fundamental human rights and ethical standards. Rules that exclude certain groups are incompatible with PHNs professional ethics.

KEYWORDS
best interests of the child, child convention act, public health nursing, undocumented migrant children

1 | BACKGROUND

According to the World Migrant Report 2020, there are approximately 13 million child refugees, 936,000 asylum-seeking children and 17 million children who have been forcibly displaced inside their own countries (UN, 2020b). Many of these migrants move outside regular migration channels and are thus irregular(ized) when they enter or reside in countries without the authorization required under national law. Those with this irregular migrant status are often referred to as "undocumented migrants." The International Organization for migration defines irregular migration as "movement that takes place outside regulatory norms of the sending, transit and receiving country" (IOM, 2011, 2020).

Undocumented migrant children (UMC) are a varied and highly vulnerable group. Children in an irregular migration situation include both children with an irregular migrant status and children whose own status is regular. They may be a citizen of the country in which they live, but also affected by the irregular status of a parent (PICUM, 2013). Moreover, UMC often shift between categories or statuses throughout their childhood. They might be rejected asylum seekers (along with their family), or unqualified for family reunification with a family relative. Some children are born with irregular migrant status because they

were born to undocumented migrant parents—for example, citizenship is not granted based on birth across the EU (PICUM, 2016, 2020).

Efforts to estimate the number of undocumented migrants have been described as "counting the uncountable" (Vollmer, 2009). There are no reliable estimates for the number of UMC in the EU (PICUM, 2016). What *is* clear is that UMC are in a position of triple vulnerability: they are children, they are migrants and they have irregular migrant status. As such, they often live in precarious situations with limited or no access to healthcare and basic social rights (PICUM, 2008, 2016). A Swedish study showed that UMC often live in extremely vulnerable situations with high poverty: many lacked adequate food, clothing and housing, and lived in fear of being deported (Ascher & Smith, 2016). Due to the latter, some undocumented migrants may avoid healthcare facilities for fear of being reported to the authorities, even though health professionals have a duty to maintain patient confidentiality (Ascher & Smith, 2016; Barkensjö et al., 2018; Kvamme & Ytrehus, 2015).

Public health nurses (PHNs), however, may represent an important way to support this group in vulnerable situations. PHNs in Norway focus on the promotion of health and prevention of disease for children, parents, teenagers and young adults through child health centers (CHCs) and school health services (Glavin et al., 2013). Central to the role of Norwegian PHNs is advocating for the needs of children, adolescents and families so they can be in control of their own lives and achieve the best possible health, quality of life and well-being. Another key part of the role is ensuring that the rights of children and adolescents are safeguarded by caregivers and by society in general (Norwegian Directorate of Health, 2021). A study on Norwegian PHNs found that they are committed to their work and defending children's rights is a strong driving force (Dahl et al., 2013). In Norway, PHNs may encounter undocumented migrants at CHCs. CHCs in Norway provide services to all children up to five years old and their parents, and examinations are free of charge. The program is voluntary, but it is used by nearly all families in Norway. The services include assessments, follow-ups, referrals, vaccinations, counselling and cooperation with other social services. PHNs play a central role in this service and are the healthcare workers who meet with families most frequently (Norwegian Directorate of Health, 2021).

1.1 | Best interests of the child

The best interests of the child principle is derived from Article 3 of the UN Convention on the Rights of the Child (OHCHR). This principle places an obligation on public and private social welfare institutions, courts of law, administrative authorities and legislative bodies to ensure that the best interests of the child are a primary consideration in all actions concerning children (UN, 1990). The OHCHR is ratified in 196 countries including Norway (Government.no, 2019) and all European member states. The right to health, regardless of legal status is one of the core rights of children under the OHCHR (UN, 1990).

Nevertheless, laws regarding irregular children's entitlements to healthcare services differ greatly around the world. In many EU member states, UMC are only entitled to emergency care, while some states (e.g., Spain) grant them the same level of services as children who are citizens (Legido-Quigley et al., 2019; PICUM, 2018).

1.2 | Access and entitlement to healthcare

In Norway, the health system is based on the "Nordic welfare model," with public funding of the health sector. There are sometimes fees, but they are low, and there are no fees for children under the age of 16; specialized healthcare is free of charge (Helsenorge, 2021b). In Norway, all children up to the age of 18 have the same rights to health and care services, but UMC do not have the right to be registered with a general practitioner (GP) (Helsenorge, 2021a).

Although the right to equal healthcare is statutory in Norway, healthcare for adult undocumented migrants is limited to emergency care "that cannot be deferred" (Helsenorge, 2021a). However, some groups of irregular adult migrants, such as pregnant women, have access to services beyond basic emergency care. Studies have documented poor health among undocumented migrants in Norway (Kvamme & Ytrehus, 2015; Øien & Sønsterudbråten, 2011), emphasizing stress-related illnesses, and mental health problems (Myhrvold & Småstuen, 2017; Myhrvold & Småstuen, 2019).

Although Norway only offers undocumented migrants a minimum right to healthcare, non-governmental organizations (NGOs) can provide access to health services in the absence of entitlement. For example, the Health Centre for Undocumented Migrants in Oslo and Bergen offers a range of services that enable undocumented migrants to consult doctors, nurses, psychologists, physiotherapists, and other specialists at no cost (Health Centre for Undocumented Migrants, 2020).

Research questions

- When caring for UMC, how do PHNs describe challenges and dilemmas in ensuring the best interests of the child?
- When caring for UMC, how do PHNs describe the conflicting demands of national policies on the one hand, and the fundamental rights and ethical standards on the other?

2 | METHODS

This study had a qualitative descriptive design. Focus group interviews and semi-structured interviews were chosen to describe PHNs' experiences in encounters with undocumented mothers and children, aiming to provide new insights into an area with limited research. Focus groups provide various points of view around which the participants can present their own perspectives and respond to what other participants say (Polit & Beck, 2020). In CHCs where it was impossible to conduct focus group interviews, semi-structured interviews were conducted individually. Semi-structured interviews are a suitable method to obtain descriptions of experiences and lived meanings of the participants' everyday life (Kvale, 2007).

2.1 | Participants and recruitment

Purposive sampling—where researchers select a sample based on their knowledge about who will likely be most informative—was employed

(Polit & Beck, 2017, 2020). First, we contacted a CHC in a big Norwegian city that we knew had experience with undocumented migrants. The leader of the CHS was responsible for the recruitment of participants. Initially, inclusion criteria were CHC health personnel that had experienced encounters with undocumented mothers, children and pregnant women. The first focus group interview therefore included three PHNs in addition to one physiotherapist and two midwives. After our preliminary analysis of data from the interview, we decided to focus solely on PHNs' encounters with undocumented women and children. Requests were sent to nine CHCs. The participants were recruited from four CHCs, and a total of seven PHNs participated. Three of these PHNs were interviewed twice. All the participants were female. Three of the PHNs had between 4 and 8 years of experience as PHNs, while the rest had more than 10 years of experience.

2.2 | Data collection

Two focus group interviews were conducted at the same CHC. Multiple interviews often not only generate more data, but can also provide better quality (Polit & Beck, 2017, 2020). To deepen the PHNs' accounts from the first focus group interview, we conducted a second focus group interview with the three PHNs from the first interview, and one additional PHN.

A semi-structured interview guide with open-ended questions addressed the participants' experience in encounters with undocumented migrant mothers and their children. Three PHNs were interviewed individually at three different CHCs. Two of the interviews were conducted at their workplace, and one via telephone. The interviews lasted between 45 min and 1 h. The first author conducted and transcribed all the interviews. All transcripts have been de-identified.

2.3 | Data analysis

To exclude data not relevant to the research questions, the first step of the analytical process involved reducing and sorting the data. In this study, data describing PHNs' encounters with undocumented mothers and children were analyzed. The transcripts were analyzed using inductive qualitative content analysis (Graneheim & Lundman, 2004). Each transcript was read separately several times to grasp the meaning of the whole. Meaning units relevant to the study's objectives were identified; these meaning units were then condensed and coded. Through a process of reflection and discussion, subthemes were identified and sorted into themes. Finally, seven subthemes and three main themes were identified (See Table 1 for an example of the analytical process). To let the PHNs' voices come through, the findings are presented in a descriptive way.

2.4 | Ethics

The project was approved by the Norwegian Social Science Data Service (NSD; number 49357). Written consent was obtained from each participant, and they were informed about their right to withdraw from the study at any time. The PHNs mainly had contact with the mothers, but occasionally with the fathers. To secure anonymity, all parents are referred to as "mothers." The empirical material was handled and stored securely in accordance with the guidelines set forth by the NSD.

3 | RESULTS

Three main themes were identified in the data analysis: building trust, ensuring the best interests of the child, and dilemmas and challenges in ensuring the best interests of the child. The main themes and subthemes are detailed in Figure 1.

3.1 | Building trust

3.1.1 | Families in vulnerable situations

The PHNs reported that, in their experience, the UMC and their parent(s) were a heterogenous group in vulnerable situations. The children's migration status depended on the migration status of the parent(s), and some children lived with a single undocumented migrant mother or with two parents, both of whom had irregular migrant status. In some cases, the child had citizenship because one of the parents had a valid residence permit. The PHNs noted that it was sometimes challenging to ascertain the precise status of children and their parent(s). Moreover, the PHNs described how some of the children and their families lived in hiding. Others had to report to the police every week and risked being deported at any time.

The PHNs primarily had contact with the mothers, whom they described as strong and resourceful. Indeed, the participants stated that they were both surprised and impressed by how well the mothers cared for their children despite their very uncertain life situation. As one PHN said: "It's really amazing how close and caring they are, and calm. They manage to relate to the child when everything else is really uncertain."

Building a relationship based on trust with the mothers is a part of PHNs' work to ensure that parents bring their children to the CHC. The PHNs explained that this trust was crucial, as many mothers are afraid that the CHC might pass on information about them to the Norwegian authorities. As one PHN noted: "They have a lot of confidence in us and at the same time a fear that we are part of the Norwegian system that they are a bit afraid of." Thus, in order to build trust, the PHNs avoided questions about migration status, especially in their first encounters with families. It was therefore difficult for the PHNs to determine whether a family had irregular migrant status.

3.1.2 | Extra time and extra consultations

Since the undocumented migrant families' situations were precarious and stressful, it took time to build trust; as such, the PHNs often gave

TABLE 1 Example of the analytical process

Meaning unit	Condensed meaning unit	Sub theme	Theme
I have recently had contact with a mother who I have experienced has followed up her children in a very good way, but I know that there have been worries and that the mother is very afraid of the police and has been very afraid to be separated from her husband	There have been worries and Mother is very afraid of the police and of being separated from husband	Families in vulnerable situations	Building trust
Sometimes I have discovered that they have no rights, I have only assumed that they have had legal stay, and suddenly they were expelled! I had not asked them: do you have legal stay in Norway? But its all about having trust in us. We shall be a safe place to come to.	Assumed they had legal stay, but they were expelled. Did not ask about legal stay. Its about having trust in us, we must be a safe place to come to		
It can also take a while to gain trust. They do not say everything at the first meeting. We can meet them both three and four times before they dare to open up.	Take a while to gain trust. Can meet them three and four times before they dare to open up	Extra time and extra consultations	
She had an address, but I could not send anything to that address. Contact was via telephone and SMS. It was easier with SMS, because I then could read the text because I did not always understand what she said on the phone.	Had an address, could not send anything to that address. Contact was via telephone and SMS. It was easier with SMS, I could read the text.	Being flexible	

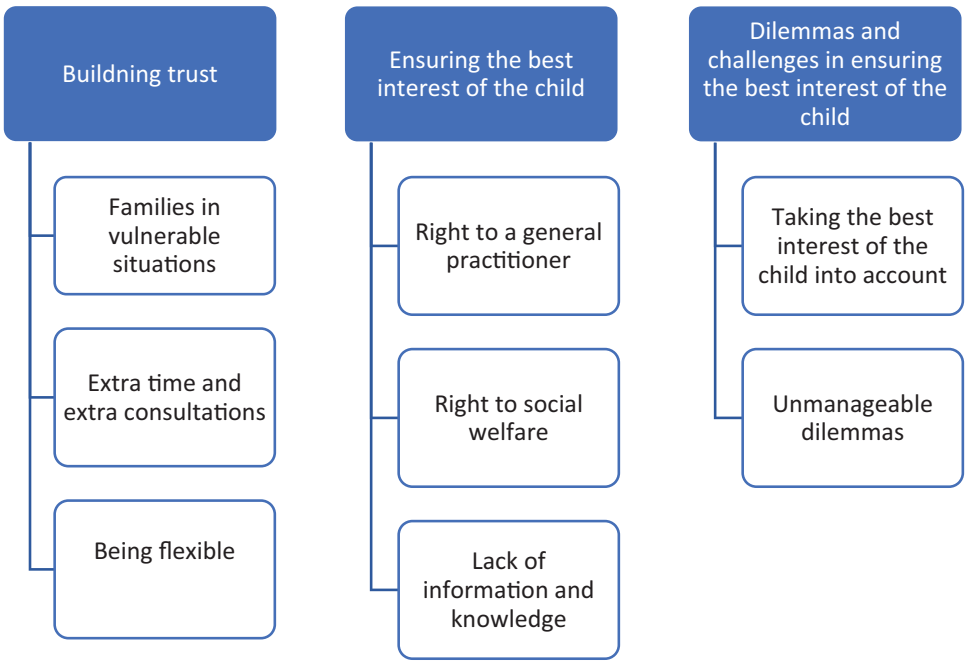

FIGURE 1 Themes and subthemes

them extra time and extra consultations. As one stated: "It can also take a while to gain trust. They do not say everything at the first meeting. We can meet them three or four times before they dare to open up." In one CHC, the PHNs appreciated that they had enough resources to provide extra follow-up in a way they considered both "professionally and personally correct."

One of the PHNs described an instance where she had provided a mother with extra time and consultations. She explained this extra follow-up by saying that she was afraid the mother might develop depression, since she was completely alone with her new-born. Many of the undocumented migrants were isolated with no family and network. The PHNs felt that they played an important and significant role

in the lives of the undocumented migrant mothers. One PHN related how a mother had brought her a box of homemade food, saying: "It's because you make me strong and less nervous."

3.1.3 | Being flexible

The PHNs saw it as important to be flexible in their work with the mothers. One PHN described how one mother turned out to belong to another district, but she decided to keep her as a patient, justifying it as follows: "I think that they have gained trust in me. They were undocumented migrants—they were in a way on the run here in the city, first with one child and then with two. It is a difficult situation."

Many PHNs also found flexible solutions for maintaining contact with undocumented migrant families lacking permanent addresses. This was seen as a major challenge: "The problem with the system here is that it is really designed to ensure good continuity for regular users … It requires that we handle it in a different way, that we make appointments in another way than we normally do." The PHNs would therefore agree on a date with the families for the next consultation and would keep in touch via telephone and SMS. This could be time consuming, however, especially when they had to use an interpreter.

3.2 | Ensuring the best interests of the child

3.2.1 | Right to a general practitioner

When a referral was necessary, challenges could arise around children's lack of the right to a GP. However, it emerged that some GPs did admit undocumented migrants. One PHN explained this in more detail:

> It is quite difficult because they do not have a GP. I have been in contact with some GPs who say they accept undocumented migrants, so that is very good—otherwise, there is the emergency room. But if there is something to follow up, I think it can actually be very difficult.

Participants also described how some doctors at the health stations did what the PHNs described as simple "GP tasks" when they had the opportunity. The PHNs also referred UMC and their parents to the Health Centre for Undocumented Migrants and to urgent care.

3.2.2 | Right to social welfare

At one CHC, the PHNs took responsibility for solving practical problems for undocumented migrant families who did not have the same rights to social welfare as Norwegian citizens. One measure was to provide clothes and equipment for the children:

> We have a somewhat informal arrangement here. If we know of someone who has some extra equipment, they bring it, and we have distributed it to those we see have needed it, so we have found practical solutions (…). One came with a new-born baby wrapped in a synthetic blanket in the middle of winter, but they got a stroller.

3.2.3 | Lack of knowledge

Although they tried to help where they could, the PHNs found they lacked information about undocumented migrants' rights to healthcare and social welfare: they described this as frustrating. Moreover, some PHNs expressed that they could have done more for the families if they had had a better overview of their rights.

The PHNs sometimes found it difficult to meet the high expectations some mothers had for them. As one participant explained, "What I sometimes find difficult is that they think I can solve all their problems." The PHNs felt that it was important to clarify to the mothers that that they did not have the power to influence the authorities concerning permanent residence or practical solutions. However, they took on the responsibility of referring the families to institutions that could give them information and help, like the Health Centre for Undocumented Migrants.

3.3 | Dilemmas and challenges in ensuring the best interests of the child

3.3.1 | Taking the best interests of the child into account

PHNs also supported families by providing statements on the best interests of the child. They were often asked by lawyers to submit such statements. One PHN described this as follows: "We have been asked to help in many cases. We have helped families by writing attachments to applications where we try to argue what is in the best interests of the child." The PHNs found it frustrating when these were not taken into consideration. For example, one PHN noted an instance in which a 15-month-old child was deported with her mother before receiving the final vaccine in the vaccination program. The PHN had tried to get the deportation postponed but was unsuccessful. Another PHN described the "completely heart-breaking" situation of a breastfeeding mother who was deported and expelled for 5 years:

> The baby was five or six months old, the mother was detained and deported from Norway, (…) and is in a country in Europe now. The father was left behind, and the kids have been given a Norwegian ID number, but he is still left behind with an infant and a small child and the mother is deported.

Participants described several similar examples of families being separated because the mother was deported. Regardless of the PHNs' views on undocumented migrants' rights and Norwegian immigration policy, they all agreed that this was not in the best interests of the child.

3.3.2 | Unmanageable dilemmas

Encountering mothers who were faced with the choice of leaving a child behind sometimes made the PHNs feel powerlessness. As this PHN explained:

> It's a tiny little child. Should she be obedient to the Norwegian authorities and move back to that country? In which case, should she bring her child or not bring her child? It is such a horrible dilemma that it is not easy for us to give any advice. It is a desperate situation, and we feel that none of the solutions are in the best interests of the child. The best thing for the child is to be with the mother and father and the Norwegian authorities do not agree on this.

The PHNs who had experiences like these believed that judgement was not present in the decisions; moreover, they felt that these decisions compromised their own "training as health personnel." As one participant expressed it: "I find it frustrating. I feel that one becomes less proud to be from Norway, that we are unable to take better care of those who are vulnerable. I feel we must apologize on behalf of Norway."

4 | DISCUSSION

4.1 | Building trust

One challenge for the PHNs in the present study was to build trust with the undocumented migrant mothers. In the PHNs' experience, the mothers were afraid that they would be reported to the authorities when they visited the CHC. This finding is supported by previous studies on undocumented migrants (Barkensjö et al., 2018; Kvamme & Ytrehus, 2015). One reason for this fear may be a lack of knowledge regarding Norwegian health professionals' duty to maintain the confidentiality of all patient information (Kvamme & Ytrehus, 2015).

In their study on irregular migrant women, Barkensjö et al. (2018) found that, when they were met with welcoming engagement and empathetic concern, their trust in the health personnel increased. Moreover, the women who felt heard and acknowledged were strengthened and encouraged by the encounters. In the present study, this is exemplified by the mother who brought food she had made to the PHN as a gift.

To build trust, the PHNs gave the mothers extra time and extra consultations. This is in line with the national professional guidelines for PHNs, which recommend additional consultations when extra support or guidance is needed (Norwegian Directorate of Health, 2021). However, research indicates that time pressure in CHCs might hinder PHNs' ability to offer additional consultations (Dahl & Clancy, 2015; NSF, 2015). Indeed, PHNs have expressed a desire for more frequent consultations and flexibility, especially in encounters with multicultural families (Glavin & Sæteren, 2016). Here, Barkensjö et al. (2018) emphasize the importance of policy-driven organizational facilitation to ensure that healthcare professionals are provided with adequate time and knowledge to provide flexible treatment for undocumented migrant women.

4.2 | Ensuring the best interests of the child

A Norwegian study found that national CHC guidelines constitute the most frequently used source of knowledge among PHNs (Weum et al., 2017). According to these guidelines, the services are to (1) be universal; (2) identify children and adolescents at risk as early as possible; (3) offer them services; and (4) refer them to other services if necessary. The CHC is also to have routines in place for cooperating with children's GPs (Norwegian Directorate of Health, 2021). However, findings from the present study indicate that immigration policy interferes with and violates the mandate that everyone should receive equal healthcare services. When UMC are not entitled to be registered with a GP, the PHNs could not follow national guidelines; instead, they were dependent on GPs who ignored the regulations and treated undocumented migrants, and on NGOs like the Health Centre for Undocumented Migrants. They also frequently referred mothers and children to urgent care services.

PHNs are also mandated to have close interdisciplinary collaboration with other municipal health services (Norwegian Directorate of Health, 2021). However, undocumented migrant families have limited or no rights to social welfare services. This lack made it difficult for the PHNs in the present study to make referrals when necessary: another example of how immigration policy and national healthcare guidelines are in conflict.

4.3 | Equity in healthcare

Norwegian health organizations (e.g., the Norwegian Nurses Organization) and humanitarian organizations (e.g., the Red Cross) have called on Norwegian authorities to grant undocumented migrants' access to healthcare based on "medical assessments, professional ethical guidelines and human rights principles." These appeals argue that, when UMC do not have the right to a GP, it violates the OHCHR (Opprop 2018, Opprop 2019).

Moreover, the UN Committee on Economic, Social and Cultural Rights (UN, 2020b) has criticized Norway for not granting irregular children the right to a GP, "which effectively hinders them from getting timely and adequate healthcare services that all children in the State party are entitled to." The UN (UN, 2020b) has also criticized the lack of rights to healthcare for adult undocumented migrants in Norway. The Committee recommends that effective measures must be taken to ensure that all persons in Norway have access to primary healthcare services, regardless of their residence status. In particular, the Committee recommends that undocumented migrants receive the right to primary healthcare services, including a GP (UN, 2020a).

4.4 | Professional ethics and violation of human rights

Studies show that caring for undocumented migrants can lead to ethical dilemmas and feeling of inadequacy among health personnel, as undocumented migrants' problems cannot be solved solely through healthcare (Barkensjö et al., 2018; Kvamme & Ytrehus, 2015; Sandblom & Mangrio, 2017). Indeed, witnessing perceived injustice—based on nonmedical criteria—can lead to moral distress and burnout among health professionals caring for undocumented migrants (Cervantes et al., 2018).

One important task for PHNs is to provide relevant information to decision-makers, to help them make decisions that are in the best interests of the child (NSF, 2015). PHNs in the present study reported that, in cases involving parental deportation, lawyers often requested statements from them about the best interests of the child. The PHNs found it frustrating when these statements were then disregarded by the authorities. This finding is supported by studies on the deportation of undocumented migrants in Norway, which conclude that the best interests of the child are often not a primary consideration (Martnes, 2021; NOAS, 2020).

The findings in this study illustrate PHNs' deep concern for the consequences of family separation, with one PHN describing the "heartbreaking" situation when a mother was deported and separated from her children and husband. This is in line with prior research showing that healthcare professionals often experience increased stress when caring for undocumented migrants (Sandblom & Mangrio, 2017). Indeed, when the PHNs in the present study found that government decisions violated what they called their professional "training," it led to frustration and feeling of powerlessness.

The International Council of Nurses (ICN) urges that the principle of universal and equitable health coverage must be applied to all individuals residing in a country regardless of their legal status; moreover, it denounces restrictive healthcare policies that limit or restrict access to healthcare services based on legal status. The ICN also endorses all other recommendations, as relayed in its 'Recommendations on Access to Health Services for Migrants in an Irregular Situation: An Expert Consensus' (Ingleby & Petrova-Benedict, 2016).

Norway has recognized the right to healthcare through its ratification of the Human Rights Convention, the UN Convention on Economic, Social and Cultural Rights, the OHCHR and other international conventions (Government.no, 2021).

Undocumented migrants' lack of a right to healthcare violates the human rights principle that migration or residence status should not determine one's rights. Thus, when Norway restricts the basic rights of undocumented migrants, this is problematic, both in light of international conventions and the Norwegian Human Rights Act—which aims to 'strengthen the position of human rights in Norwegian law' (Lovdata, 2014).

The Human Rights Act states that the international conventions should take precedence over the provisions of other legislation, but this does not happen regarding UMC's right to a GP, and their parents' rights to primary healthcare. According to Ivanov and Oden (2013) PHNs have always been in the forefront of providing care with a social conscience. Rights-based care provides nurses with the tools to ensure that individuals, populations and communities receive care that reflects humane practices and does not violate their human rights.

4.5 | Strategies for dealing with 'paradoxical demands'

A European study (Karl-Trummer et al., 2009) found that healthcare professionals experienced the burden of accommodating the "paradoxical demands" of simultaneously including and excluding undocumented migrants. The study identified three strategies healthcare professionals employ to handle these paradoxes without violating professional ethics codes, human rights or national laws.

The first strategy, functional ignorance, may be seen in the present study when PHNs referred patients to GPs who ignored regulations and treated undocumented migrants. This finding is supported by other Norwegian studies (Haddeland, 2020; Karlsen, 2015; Aarseth et al., 2016). Aarseth et al. (2016), in their study of Norwegian GPs, found that 23% of Norwegian GPs who participated in the research had helped undocumented migrants, and that 70% of them would continue to do so. Another example of functional ignorance in the present study is the PHN who continued to treat the irregular migrant mother who belonged to another district. Ignoring patients' legal status enables health personnel to act in accordance with the principles of human rights and professional ethics without getting into conflict with state demands (Karl-Trummer et al., 2009).

The second strategy, structural compensation, is when NGOs provide necessary healthcare for undocumented migrants to compensate for their lack of rights in the health system. As an example, the Health Centre for Undocumented Migrants offers a parallel healthcare service for undocumented migrants in Norway, often taking on the role of GP (Ottesen et al., 2015).

The third strategy, informal solidarity, is an individual strategy. It can be seen, for example, when nurses and doctors work for free at health centres for undocumented migrants. Informal solidarity is important for enabling functional ignorance and structural compensation. In both cases, this solidarity is dependent on the activities of individual people in structural settings that promote these activities. Informal solidarity also occurs when doctors at hospitals do not charge undocumented migrants for treatment (Haddeland, 2020). In the present study, an example of informal solidarity can be seen in PHNs' description of collecting clothes and equipment at a CHC and distributing these to UMC.

5 | STRENGTHS AND LIMITATIONS

The aim of this study was to reveal insights into PHNs' encounters with undocumented mothers and children. A strength of the study is that it contributes knowledge about a topic that has received

little to no empirical attention. The results of this study might therefore be useful not only for PHNs, but also for policymakers. However, it should be noted that the participants in the present study were recruited from CHCs in a large city: it is possible that PHNs from other locations might have described challenges and dilemmas in their encounters with undocumented mothers and children differently.

5.1 | Methodological considerations

Both authors read the transcripts several times. The first author was responsible for the analysis, while the co-author asked critical questions during each step of the analysis and carefully followed up on the entire analysis and categorization process (Elo et al., 2014).

The researchers' preunderstanding can influence data collection and interpretation. Both researchers have worked with undocumented migrants and have conducted research on undocumented migrant women. The authors were aware of their preunderstanding of the field throughout the interpretative process; critical reflection and discussion contributed to limiting a biased interpretative process.

To enhance transferability, the recruitment of participants, collection of data and process of analysis are described together with a rich presentation of the results supported by relevant quotations (Graneheim & Lundman, 2004). This use of quotations also enhances the credibility and conformability of the results by prioritizing the voice of the participants over that of the researcher(s) (Graneheim et al., 2017). The PHNs willingly and openly shared their experiences and were able to reflect on their experiences and communicate effectively. This contributed to the richness of the empirical material (Polit & Beck, 2017).

6 | CONCLUSION

The aim of this study was to describe how PHNs experienced challenges and dilemmas in ensuring the best interests of the undocumented migrant child. When UMC are not entitled to be registered with a GP, the PHNs were dependent on GPs who ignored the regulations, and on NGOs like the Health Centre for Undocumented migrants. Rules that discriminate against or exclude certain groups are incompatible with PHNs' professional ethics. Immigration policy should not interfere with the ethical obligation to provide care for all regardless of residence status. A rights-based approach to PHN practice may ensure that human rights principles guide patient care. Policies and practices that discriminate against children according to their residence status should be revised. More research is required on how the best interests of the child principle can be applied in public health nursing practice in encounters with undocumented migrants. Future studies should also include undocumented migrant parents' experiences of encounters with PHNs.

DATA AVAILABILITY STATEMENT

Author elects to not share data. Research data are not shared.

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