IENE 8

EMPOWERING MIGRANT AND REFUGEE FAMILIES WITH PARENTING SKILLS

Curriculum Content Map

Intellectual Output 2.2

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1. Rationale

Refugee parents are central to protecting children from all kinds of harm. However, caring for children during the phases leading to resettlement is unimaginably hard for refugee and migrant parents who are under extreme and unique circumstances. The creation of the curriculum for nurses and other health professionals and volunteers working with migrant and refugee families responds to the training demands that have been identified to better prepare frontline caregivers to respond to the support needs of families 'on the go'. The needs of refugee families in transit are different from those in resettlement contexts (Williams, 2010). Research indicates that disruptions of family structure and parenting roles, values, and practices which are largely culturally informed, occur as early as during pre-flight stages (e.g. Williams, 2010). Furthermore, early interventions with families after trauma have been found beneficial (Dyregrov, Gjestad, & Raundalen, 2002).

The curriculum aims to better enable health workers to provide support , knowledge, and skills on parenting and child-family health care needs, under extreme and unique conditions. This curriculum has the objective to develop health workers' competencies in providing culturally competent and compassionate support to families who are part of the new waves of migration primarily from Syria, Iraq, and Afghanistan who arrive in Greece through Turkey. This curriculum aims also to help health workers and volunteers to develop personal/peer strategies to cope with the high levels of their own personal trauma as a result of what they encounter whilst doing their job.

This curriculum framework is informed by the evidence gathered under *IO 1. Mapping National and International Literature*, and is guided by PTT/IENE European model to empower migrant and refugee families with parenting skills. The model is detailed in *IO 2.1. Curriculum Model*. The model is based on the four components of cultural competent and compassionate health care: a) **cultural awareness**, b) **cultural knowledge**, c) **cultural sensitivity**, and d) **cultural competence**. The model provides the values, philosophy, and educational principles, as well as a conceptual map for potential content to aid health care trainers in developing curriculum and educational tools for health care professionals.

In addition to the curriculum, healthcare workers/volunteers and refugees/migrants will have easy access to information relevant to migration and wellbeing; the sharing of information and knowledge between healthcare workers/volunteers and refugees/migrants will be facilitated through the KHub portal (http://ienerefugeehub.eu/training/).

2. Educational philosophy

We believe that a curriculum designed to promote culturally competent and compassionate support to migrant and refugee families in transit should be based on respect, equity, compassion, cultural competence, courage, social skills, flexibility, and tolerance. Such a curriculum should build on the knowledge and skills which both health workers and parents already have; it should also encourage them to be reflexive, self-compassionate, and hopeful in

the challenging situations they find themselves. They are also invited to think of themselves as example through role modelling and coaching.

3. Definitions

In addition to the list of values and beliefs listed and described in IO 2.1 Curriculum Model, here, we are providing an additional list of key words and concepts.

Asylum Seeker

A person who has applied to the Immigration and Nationality department of a host country to be recognised as a refugee but who has not yet received a decision or is in the process of appealing against an initial rejection of a claim for asylum.

Courage

Definitions of courage vary, but there are some common components. In terms of nursing practice, courage is probably best understood through the analysis of nursing literature undertaken by Hawkins and Morse (2014), which described courage as ' an inner strength or moral virtue fundamental to an individual's capacity for caring behaviours or compassion, or the ability to cope' (p. 265). Hawkins and Morse conclude with the definition: 'Despite fear for self and others, courage is ethical-moral "risk-taking" action(s) with the intent to ensure safe patient care'. So, as Hawkins and Morse (2014, p. 267) point out, courage differs from compassion – it enables risk-taking actions. Lindh et al (2010) undertook a theoretical analysis of 'courage', and identified four philosophical views: Courage as an ontological concept According to this view, courage is an inherent characteristic of being human. As human beings, we need courage to make day-to-day decisions. If a human being does not fulfil his/her moral duties or obligations, guilt may be experienced. Courage as a moral virtue The role of courage in ethics and moral life can be found in the work of Aristotle (384-322 BC), who viewed courage as a moral virtue (Lindh, Barbosa da Silva, Berg, & Severinsson, 2010). Courage as a property of an ethical act 'Moral courage is grounded in compassion, sensitivity and recognising other people's suffering' (Lindh et al., 2010, p. 561). It is further concerned with recognising when something is wrong, and feeling the responsibility to respond. The opposite of moral courage would be a reluctance to get involved when someone is being unjustly treated. Courage as a creative capacity In having the courage to challenge the status quo, something new can be brought into being and so courage can bring about change. In summary: 'Courage enables us to do the right thing for the people we care for, to speak up when we have concerns and to have the personal strength and vision to innovate and to embrace new ways of working' (Commissioning Board Chief Nursing Officer & DH Chief Nursing Adviser, 2012, p. 13).

Empowerment

Empowerment refers to the "process of enhancing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes" (World Bank official website). Empowerment is mainly related to economic poverty but also to social

arrangements (social structure, social class), governance-local or national. If we summarize the definition of Empowerment we could refer only to Liberty which translates into: Access to Information, Access to Basic Services, and Participation to Public Decision etc.

Having all of the above you are empowered to make a wider range of choices, you are in the position of real influencing your own life and change its course whenever you feel to. We could say that in healthcare empowerment is Access to Basic Services but also to the opportunity of choosing your health provider.

Ethnic Cleansing

Ethnic cleansing is a term that has come to be used broadly to describe all forms of ethnically inspired violence, ranging from murder, rape, and torture to the forcible removal of populations. A 1993 United Nations Commission defined it more specifically as, "the planned deliberate removal from a specific territory, persons of a particular ethnic group, by force or intimidation, in order to render that area ethnically homogenous."

Family types

- Nuclear family: a couple and dependent children
- Single parent family: only one of the two parents is present
- Extended family: family which extends beyond the nuclear family to include grandparents and other relatives
- Childless family: a family where children are not present (e.g. separated or lost children)
- Stepfamily: one or both parents are not biologically related to the child/children)
- Grandparent family: a family with grandchildren and no parents present in the intervening generation.

Migrant

IOM defines a migrant as any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is. (https://www.iom.int/who-is-a-migrant, accessed on 8.5.19)

Mindfulness

Mindfulness has its origins in Buddhist philosophy and was taught in order to alleviate suffering and nurture compassion (White, 2014). Mindfulness entails purpose, awareness and attention in the present moment. 'Mindfulness is a transformative process where one develops an increasing ability to 'experience being present', with 'acceptance', 'attention' and 'awareness' (White, 2014, p. 282).

Presence

The concept of presence evolved from the philosophical roots of several disciplines (McKivergin & Daubenmire, 1994). It relates to the essence of nursing practice and is

commensurate with nursing theories of care. McKivergin and Daubenmire argue that the provision of compassionate care requires a sensitivity to the many dimensions of the self and invoke the theory of presence, first introduced into nursing literature in 1976 by Paterson and Zderad, as a route to understanding therapeutic relationships that entail 'being with' as well as 'doing with'. Presence entails personal and professional dimensions: the personal uniqueness that each nurse brings to the nurse-patient encounter, and the professional context of that encounter, which is goal-directed. In the belief that the process of being present can be consciously explored, experienced, evoked, taught and learned, McKivergin and Daubenmire operationalise the process at different levels of practice and identify related types of contact and skills needed for the practice of presence in nursing: physical, psychological and therapeutic presence. As a nurse moves through these levels of presence, the nature of contact moves from 'being there' to 'being with' to 'relating to the patient as whole being to whole being'. Van der Cingel (2011)extends these notions by arguing that 'being there' is a conscious choice and not a coincidence; the nurse notices the need for presence. Presence is intentional.

Refugee

Anyone who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is unable, or, owing to such fear, is unwilling to return to the country of her/his nationality or former habitual residence (United Nations Convention 1951).

Social norms

There are many different definitions of social norm, but all of them emphasise the importance of shared expectations or informal rules among a set of people (a reference group) as to how people should behave. Most also agree that norms are held in place through social rewards for people who conform to them (e.g. other people's approval, standing in the community) and social sanctions against people who do not (such as gossip, being ostracised or violence). Some definitions consider the informal rule plus the resulting pattern of behaviour to comprise the norm; others consider the norm to be the informal rule – in other words, a standard of behaviour that people do not necessarily meet (Marcus, Harper, Brodbeck, & Page, 2015).

Resilience

The capacity to recover quickly from difficulties; toughness (Oxford Dictionary). The concept of resilience is typically presented as the property of individuals, communities, organizations, or service sectors withstand stress and challenges. Resilience is accordingly understood to be the "capacity to endure, adapt and generate new ways of thinking and functioning in the context of change, uncertainty or adversity" (Seaman, McNeice, Yates, & McLean, 2014).

4. Challenges for migrant and refugee families

The analysis of the evidence collected in *IO 1. Mapping National and International Literature* resulted in the following four macro-themes which are also summarised in **Figure 1**:

1. **Up-rootedness.** Refugees come from diverse contexts and circumstances. However, they share common reasons to flee from their countries, such as conflicts and war, persecution, mass violence and torture, and natural disasters. Amongst the immediate consequences of forced migration living in temporary, precarious camps and shelters is a tangible challenge which poses refugee families numerous environmental difficulties. Health threatening conditions, extreme dispossession, family separation, and the loss of support from the network of relatives and community members are dramatic changes affecting refugees' parenting experience. Camps often are places with low levels of hygiene and appalling few facilities. Less known are however other kinds of risks affecting living in camps, such as community violence, bullying, sexual abuses, human trafficking and smuggling. Immediate response is therefore directed to meet basic needs, like: housing and food; personal, cooking and household hygiene; places of worship and aggregation; and financial support. Awareness should be raised regarding human rights and law for the protection of vulnerable migrants, refugees, and asylum seekers.
2. **Spatio-temporal Uncertainty**. The spatio-temporal uncertainty of refugees can be prolonged, sometimes for years, due to ongoing hostile conditions in their country of origin which makes the return impossible. On the other side, restrictive migration policies and asylum systems, as well as extenuating bureaucratic processes, makes resettlement and integration into a new country slow. Refugees' limbo–like situation is a source of sense of insecurity, chaos, and persistent stress, which adds onto the devastating effects of the traumatising events which led to decision to migrate. Pre-settlement, stateless refugees dwell in marginality, they are more vulnerable to discrimination and exploitation, and are often lacking access to welfare and education. As typical of waiting, refugees in transit have to suffer monotony and meaningfulness, which can be even harder for children not attending school regularly or not having available resources to play. In this situation, interpreters and cultural brokers are vital in order to assist refugees not only along their formal asylum process, but more broadly to effectively interact with the foreign context. NGOs services must be able to reach camps and shelters, and the provision of education for the underage population is crucial. The facilitation of the establishment of social networks and the restoration of healthy daily routines are also important services to be offered in order to enable positive parenting among refugee families in transit.
3. **Trauma and Abuses**. Forced migrants, refugees, and asylum seekers have frequently gone through themselves or have witnessed incredible atrocities. The traumas and abuses refugees suffer are related to different types of violence affecting them, such as ethnic, political, gender-based, physical and emotional. As a consequence, poor mental and physical health conditions are spread, and these can have in turn a devastating impact on parenting process. Hence, regular screenings and psychosocial first aid is key

as well as are parenting programmes helping refugee and migrant families to recovery and restore positive relationships.

4. **Parental Powerlessness**. The combination of geographic, cultural, and social up-rootedness, the condition of uncertainty, and the violence suffered, all contribute to increase risks of **a loss of identity as parents**, literature suggests. A sense of parental powerlessness - due to the profound pre-departure losses, disruptions, and traumatic events suffered - has been found affecting refugee parents. Crucially, a 'power shift from internal control to external control' over decision-making is experienced by the refugee family in transit (Williams, 2010, p. 36). This loss of control implies the disruption of parent-child relationship and can trigger a sense of guilt and inadequacy whereby parents feel that the best they can do for their children is "never good enough" (Kelly, 2016). Parents' emotionally distraught state can lead to overprotectiveness, harshness, and reversal of parent-child roles (Browne, 2018). Parents' poor wellbeing, impaired parenting, and unhappy family environments are high risk factors for children to develop insecure attachments and mental health distress at least as strongly as the pre-departure and journey-related traumatic events they have gone through (Miller & Jordans, 2016). This set of acute Adverse Childhood Experiences (ACEs)* can result in internalising and externalising behaviour problems. For instance, it has been found that Syrian refugee children present trauma symptoms, such as bed wetting, regressive behaviours, fear of loud noises and bright lights, in addition to increased aggressive and violent behaviours, negative emotions, and bad parent-child communication (El-Khani, Ulph, Peters, & Calam, 2016). A related study revealed that around half of Syrian refugee children presented clinical level of anxiety, withdrawnness, fear, and other emotional and behavioural problems (Cartwright, El-Khani, Subryan, & Calam, 2015).

Response must therefore focus on supporting both children and parents, with the aim of improving the family environment as a whole. In fact, a mere focus on children could run the risk of failing to address critical sources of stress that affect children. Furthermore, support devoted to fostering resilience and which target environmental, daily stressors should be integrated with intervention healing distress (Miller & Jordans, 2016). Age-related child focused support, in our model, includes activities relying on play and learning to foster emotional and physical wellbeing, safe and appropriate behavioural discipline, the value of respect and the enjoyment of positive relation based on guidance. Parent-focused support hinges on nurturing self-compassion and motivation, familial cohesion and child-parent communication, being based on mindfulness and stress reduction techniques. **Figure 1** below summarises the challenges for migrant and refugees families in accordance to the four macro-themes stemming from the extensive review *IO 1. Mapping National and International Literature.*

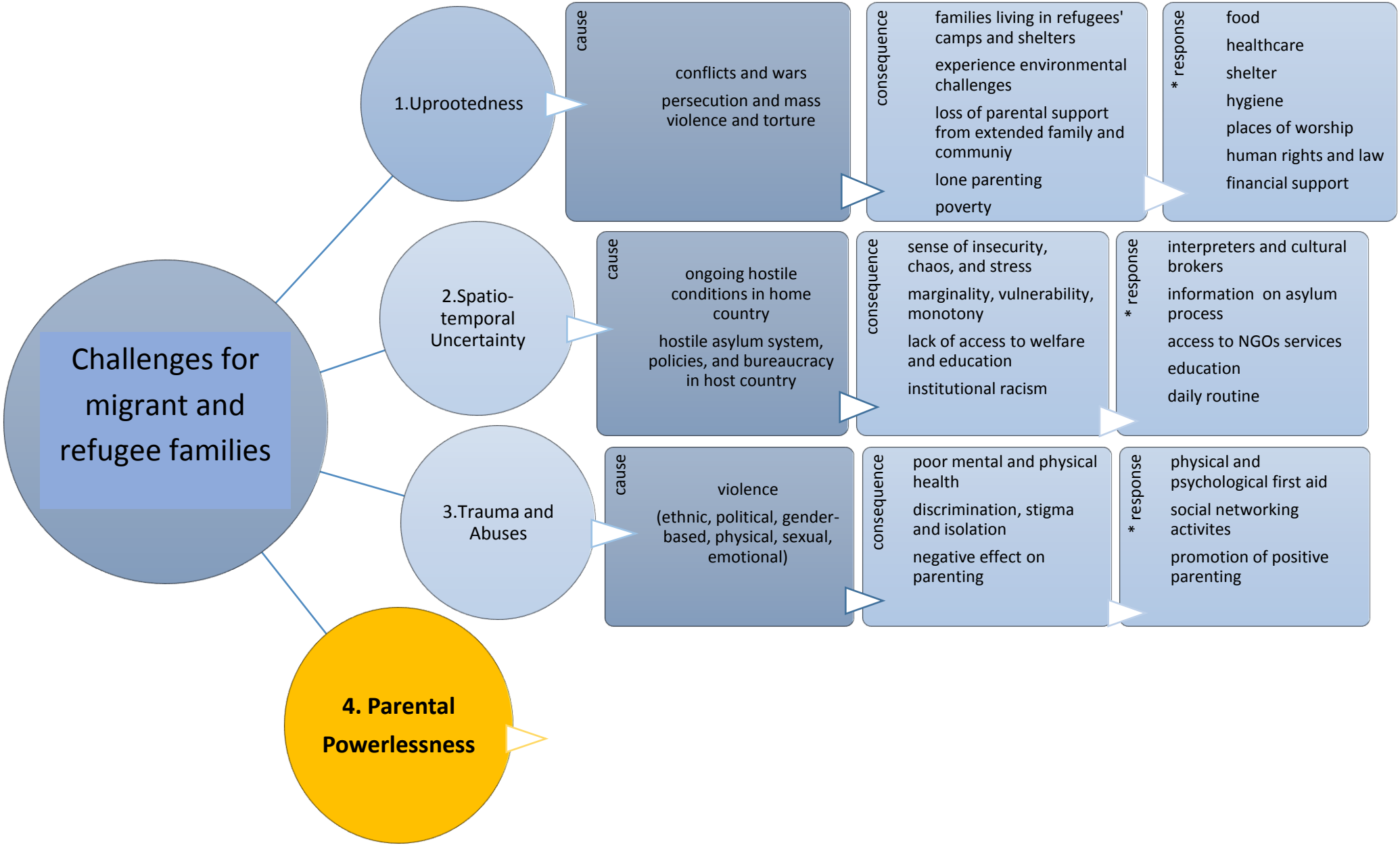


Figure 1. Challenges for refugee families

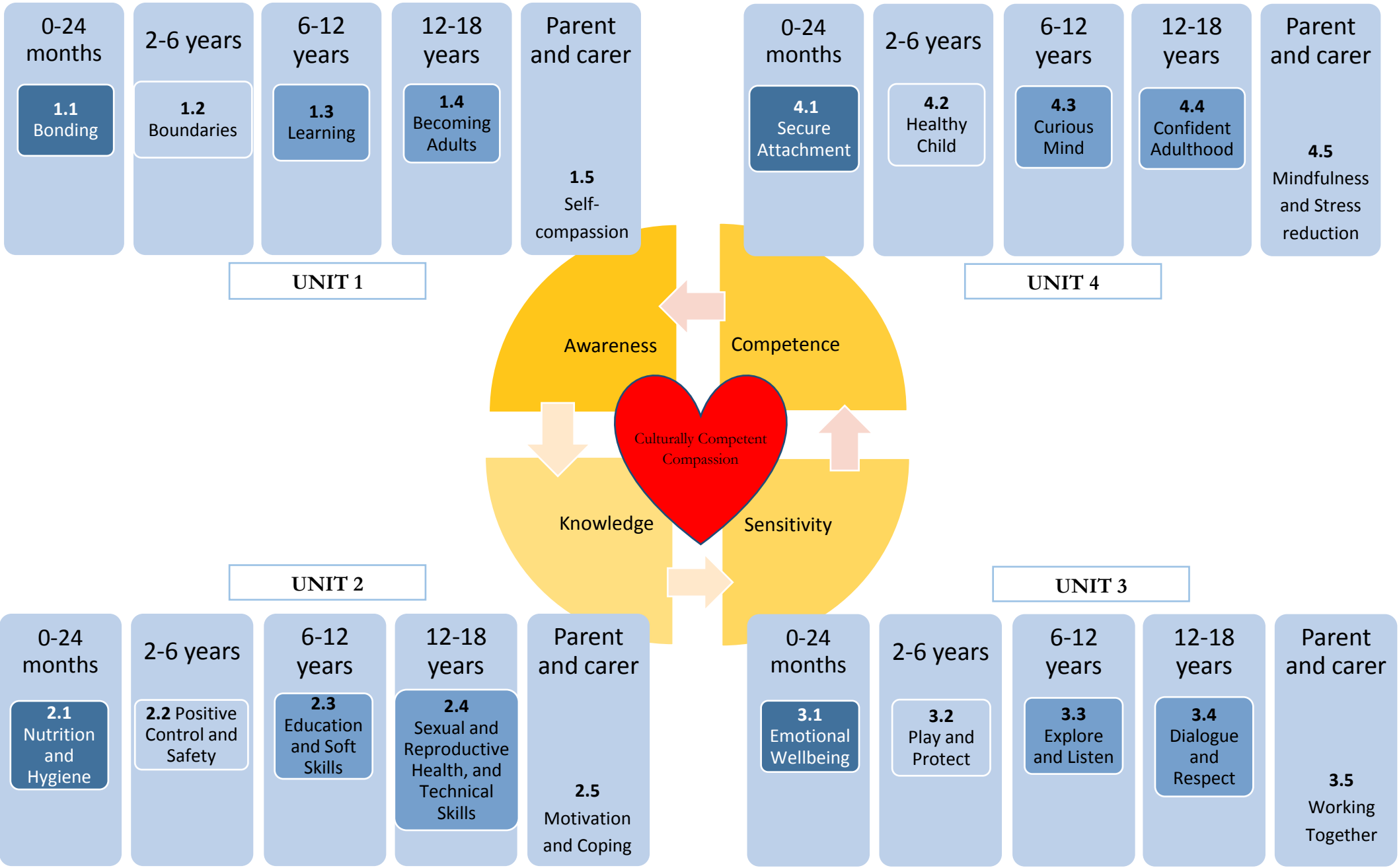
5. Aims and objectives of curriculum

This curriculum aims to inform an innovative training for nurses and other health professionals and volunteers, to enable them to provide support, knowledge, and skills on parenting and child-family health care needs, under extreme and unique circumstances. This curriculum aspires to develop health workers' competencies in providing culturally competent and compassionate support to pre-settlement families who are part of the new waves of migration primarily from Syria, Iraq, and Afghanistan who arrive in Greece through Turkey. This curriculum aims also to help health workers and volunteers to develop personal/peer strategies to cope with the high levels of their own personal trauma as a result of what they encounter whilst doing their job.

The curriculum is composed of four learning **UNITS** following the four constructs of the PTT/IENE Model and the conceptual PTT /IENE8 (European Training Model for the Caregivers of Migrant and Refugee Families in Transit) as outlined in the document *IO 2.1 Curriculum Model*. Both the model and the curriculum itself are informed by the evidence gathered under *IO 1. Mapping National and International Literature*. Each unit comprises five subunits: four subunits covering age related topics relevant to children and one subunit covering issues relevant to the adult, intended as the parent but also as the caregiver. **UNIT 1** lies within the construct of *Awareness* and aims to enhance understanding of key elements of child development and child-parent relationship which are largely culturally informed. Health workers and volunteers will learn how to help parents become more aware of their cultural beliefs and values in terms of parenting. They will help them focus on the key phases of a child development (e.g. bonding, boundaries, and coming to age), drawing on from the wealth of knowledge and tradition parents already have. The subunit devoted to adults focuses on learning self-compassion which is rooted in self-awareness.

UNIT 2 resting in the construct of *Knowledge* has the objective of helping parents to cement some basic notions crucial to the age phases of their children, such as nutrition, hygiene, appropriate discipline, soft skills, and sexual and reproductive health. Similarly to the first unit, also here the teaching/learning experience is rooted in the capitalisation of what parents already know and in a culturally competent and compassionate approach (Papadopoulos, 2018). The subunit for adults aims at boosting coping strategies and motivation. Within the domain of *Sensitivity*, **UNIT 3** revolves around the development of positive feelings and attitudes aimed at establishing healthy relationship, where both parent and child can feel satisfied (e.g., playfulness, dialogue, respect). The importance of working cooperatively will be delivered for the adults in this unit. Finally, the last **UNIT 4** is about harvesting the fruits from the previous units, and empowering parents to feel competent and compassion parents able to practice a compassionate upbringing of their children within their cultural values and beliefs. This unit belongs to the *Competence* domain and covers topics such as secure attachment, healthy child, curious mind, confident adults. Mindfulness and stress reduction is the objective to be reached by the adult in this unit. Figure 2 offers an overview of the curriculum content map.

Figure 2. Curriculum Content Map



6. Structure of the curriculum

The curriculum will consist of four **UNITS** as described above, in addition to a pre-course preparation phase and post-course reflection and evaluation phase. Training will be **20 hours**, and structured as follow:

a) 6 hours of self-directed pre-course preparation (all materials will be provided on-line and students go through them on their own);
b) 8 hours of classroom learning where the four **UNITS** are covered (face to face learning in classroom): 2 hours approximately for each unit, 4 units with 5 sub-modules (approx. 25 minutes for each Sub-module, divided in 5 minutes presentation – 15 minutes for activities - 5 minutes for group discussion);
c) 6 hours post-course reflection and evaluation.

	A	K	S	C
Self-directed Learning [6 h]	X	X		
DAY 1 [8 hrs]		X	X	X
Reflection [6 hrs]	X		X	X

A= AWARE, K= KNOWLEDGEABLE, S= SENSITIVE, C=COMPETENT

7. Template for Bitesized Learning Units

Each partner will cover three **UNITS** based on their chosen concepts.

Partner	FOCUS	Unit 1	FOCUS	Unit 2
CUT	Becoming adults	1.4		
MDX	Boundaries	1.2		
EDUNET	Learning	1.3	Education and Soft-skills	2.3
NKUA	Self-compassion	1.5	Positive control and Safety	2.2
Doctors of the World			Nutrition and Hygiene + Sexual and Reproductive Health, and Technical Skills	2.1, 2.4
St Augustinus				
C&B	Bonding	1.1	Motivation and Coping	2.5

Partner	FOCUS	Unit 3	FOCUS	Unit 4
CUT			Confident Adulthood	4.4
MDX	Play and protect	3.2	Curious Mind	4.3
EDUNET	Explore and listen	3.3		
NKUA			Secure Attachment	4.1
Doctors of the World			Healthy Child	4.2
St Augustinus	Dialogue and Respect + Working together	3.4, 3.5	Mindfulness and Stress reduction	4.5
C&B	Emotional wellbeing	3.1		

The bite-sized learning units will have the following structure:

Title page: Title, authors, date

Page 1:

- ✓ Learning Objectives: 1 to 3
- ✓ What is… (Definition)
- ✓ Relevance o IENE 8
- ✓ Key theories in half a page

Page 2:

- ✓ Three power point slides with key points and diagrams/ pictures from research

Page 3:

- ✓ • Activity (e.g. quiz, or another type- one third of a page
- ✓ • Reflection on one issue from tis BSL – space for one paragraph
- ✓ • Self-assessment – Third of a page (this is a suggestion)

Page 4:

- ✓ • References
- ✓ • Links to websites and /or documents

8. Assessment strategies (self and peer)

Assessment is about several things at once - It is about reporting on students' achievements and about teaching them better through expressing to them more clearly the goals of our curricula. It is about measuring student learning; it is about diagnosing misunderstandings in order to help students to learn more effectively. It concerns the quality of the teaching as well as the quality of the learning (Ramsden, 2003, p. 177).

Formative assessment (monitor caregivers learning) has two purposes: help learners identify their strengths and weaknesses and target areas that need work, and help them recognize where parents are struggling and address problems immediately.

Summative assessment (evaluate caregivers learning) in order to: measure what the learners have achieved and demonstrate that standards are appropriate.

Self-assessment involves various tasks such as self-reflection, journal/diary notes, quizzes provided within a course, etc.

Curriculum structure and assessment activities, we may include:

a) 6 hours of self-directed learning (all materials will be provided on-line and learners go through them on their own); promote independent learning helping caregivers to take increasing responsibilities for their own progress:

- draw a concept map to be illustrated in class to represent their understanding of a topic;

b) 8 hours of classroom learning (face to face learning in a classroom):

- give opportunities in lessons to discuss reflect on problem solving and reasoning strategies. comparing and evaluating approaches;
- submit two or three sentences identifying the main point of the lectures;

d) 6 hours reflection:

- Encourage self-reflection on their learning and produce an action plan for their implementation of their learning with regards to their work with refugee parents.

9. Evaluation strategies

Through evaluation we can discover whether the curriculum is fulfilling its purpose and whether trainees are actually learning.
The evaluation of the outputs is divided into four sections as follows:

1. Quality of the curriculum: coverage of the identified learning needs, expectations and learning goals of the target groups, the relevance of the structure of the training sessions, learning activities and the learning outputs met.
   - Verification: trainees participating in the training workshops; evaluation questionnaires administered;
2. Quality of training methodology: efficiency of management of the training, activation and motivation of the participants, communication and support for their learning opportunities for individual pathways.
   - Verification: trainees participating in the training workshops; evaluation questionnaires administered; evaluation report of IO3 leader.
3. Quality of training outputs: added value of knowledge skills and competences acquired by the participants; the applicability of knowledge gained to practice; the degree of assimilation of knowledge.
   - Verification: trainees participating in the training workshops; evaluation questionnaires administered; evaluation report of IO3 leader.

4. Quality of Bitesized Tools: coverage of the identified learning needs of migrant and refugee families in the improvement of parenting skills, health and social care of children; coverage competences for health professionals and volunteers for training of the migrant and refugee parents; innovation and quality of the content; presentation of the training materials, intuitive and friendly presentation, efficiency for information and learning.

- Verification: experts from partner organisations; validation; report of IO4 leader.

10. Reading list, on-line resources list

Each partner will provide participants with a reading list in the native language

http://www.ieneproject.eu/

https://ienetools.wordpress.com/

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