Interprofessional approach to refugee health: PREP IP online course

Course Open eBook

Interprofessional approach to refugee health

Erasmus+ Persons with Refugee Experience Education Project – Interprofessional PREP IP

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PREP IP Persons with Refugee experience Education Project - Interprofessional

Co-funded by the European Union

Persons with Refugee Experience Education Project – Interprofessional (PREP IP) is a partnership project between five universities and two organizations providing health care services to refugees and migrants, co-funded by Erasmus+ Programme of the European Union

The work in the PREP IP project builds on results and experiences from of previous projects within the partner organisations, calling for interprofessional and intersectoral strategies to ensure sustainable services for refugees. PREP IP crosses the boundaries of professions by targeting various professions, sectors, topics, countries, and cultures. Within the context of the current global refugee crisis, there is a growing need for interprofessional education for professionals working with refugees.

Table of Contents

Foreword

This open book is based on the online course Interprofessional approach to refugee health that was developed by developed by partners in the Persons with Refugee Experiences Education Project - Interprofessional (PREP IP) and co-funded by the European Union. Project partners are:

- Western Norway University of Applied Sciences, Norway (lead)
- Universitat de Vic – Universitat Central de Catalunya | UVic, Spain
- Trinity College Dublin, Ireland
- HAWK University of Applied Sciences and Arts, Germany
- Bergen Municipality – Centre for Migration Health, Norway
- Independent Doctors Association (IDA), Turkiye
- HAN University of Applied Sciences, The Netherlands

This book includes materials and activities downloaded from the course learning management system and edited to serve as a resource for educators and practitioners interested in refugee health who do not have access to Canvas Commons where the course is shared under Creative Commons license Attribution- Non-Commercial - Share Alike (CC BY-NC-SA). This book is also licensed under CC BY-NC-SA allowing users to distribute, remix, adapt, and build upon the material in any medium or format for noncommercial purposes only, and only so long as attribution is given to the creator. If you remix, adapt, or build upon the material, you must license the modified material under identical terms.

Welcome to the course!

This course examines interprofessional approaches to refugee health, by focusing on health and rehabilitation challenges caused by global migrations. It reviews health, political, environmental, social, technological, legal and environmental causes and consequences of this phenomenon. The course deepens students' understanding of diverse aspects and challenges to refugee health including both physical and mental health. It prepares students for interprofessional collaboration to address them within different contexts and systems while upholding human rights and promoting equity and inclusion of refugees.

In the course you examine experiences of refugees in new health and social contexts as well as barriers and enablers to accessing health and social services from an interprofessional and intersectoral perspective. Along with competence for interprofessional collaboration you build your cultural competence to work with refugees of diverse cultural backgrounds and in different languages.

Learning Outcomes

A student who has completed the course should have the following learning outcomes
Knowledge:
The student...

- has advanced knowledge within the field of refugee health related to interprofessional health and social care collaboration
- has thorough knowledge of theories, frameworks, concepts and methods in the field (e.g. social justice, human rights…)
- can apply knowledge of refugee health to health and social care practice
- can analyze health and social issues as well as resources of refugees based on the history, traditions, contexts, and individual experiences

Skills:
The student...

- can analyze and deal critically with various sources of information and use them to provide rationale for meaningful engagement of people with refugee experiences in health and social care
- can analyze theories, methods and interpretations in the field of refugee health and work independently and in teams to address practical and theoretical problems
- can identify, appraise and use different types of evidence to deliver effective informed care
- can advocate on behalf of clients, from community- to policy level, to improve their access to appropriate resources and services that support their inclusion in society

General competence (EQF responsibility and autonomy)
The student...

- can communicate and collaborate with other health and social care professionals to optimize interprofessional team performance in refugee health and social care setting
- demonstrate a critical awareness of ethical questions regarding refugee health
- can apply refugee health knowledge and skills in varied contexts integrating perspectives of persons with refugee experiences and professionals
- can elevate narratives of persons with refugee experiences to inform practice and support inclusion into community

Course Modules

The course has four modules developed by partners in this project:

Module 1: Global Migrations (CMH)

This module aims to provide a general overview of the theoretical content related to refugees by highlighting the unique conditions that refugees experience. Additionally, the module will explore how healthcare professionals address the specific needs and challenges of refugees, all within the context of the basic human rights concept.

The module will cover key theoretical concepts, explore case studies, and offer practical guidance on providing adequate care to refugees. By the end of this module, learners will have gained a deeper understanding of the complex challenges facing refugees and the critical role that healthcare professionals play in meeting their unique needs.

Go-To Module ①

Module 2: Refugee experiences in new health and social context (TCD)

This module will focus on exploring and recognizing the individuality and unique experiences of people with refugee experience. It will cover strategies that health professionals can use to identify and respond to the specific needs and preferences of people using their services.

The module will highlight the importance of continual learning in this area of practice and how critical reflection and appraisal of one's practice and outcomes are key components to ensure effective practice now and in the future. The concepts of person-centered practice and creating therapeutic space are explored and how these approaches can be practically implemented by different professions working collaboratively in providing services for people with refugee experience.

Go-To Module ②

Module 3: Navigating Health Systems and Transforming Practice through Interprofessional and Intersectoral Collaboration (HVL)

This module introduces theoretical and practical aspects of working collaboratively with persons with refugee experiences and professionals across disciplines, professions and sectors.

It focuses on relationship building, communication and collaboration as foundations for quality health services while supporting persons with refugee experiences to access the care they need within and beyond the health systems.

Go-To Module ③

Module 4: Diversity in Society & in Health Care (HAWK)

This module will look at diversity-sensitive interprofessional services for persons with refugee experience as a response to increasing societal diversity and the associated demands for equal health opportunities. It will introduce relevant key concepts such as culture, diversity, intersectionality and racism.

The module will cover essential aspects of culturally responsive practice and strategies for successful cross-cultural communication, questions of interprofessional ethical practice in refugee health and possibilities of professionals to contribute to advocacy and empowerment in the field of refugee health.

Go-To Module ④

Module 5: Social and Occupational Determinants of Mental Health (UVic)

This module will reflect on how to improve the well-being of the refugee community focusing on its social and occupational determinants. It will introduce relevant concepts, frameworks, and theories related to mental health, and the social and occupational determinants.

The module will go in-depth into the social determinants of mental health from the World Health Organization. It will also develop the occupational determinants of mental health, developing concepts such as occupational justice. Work and social entrepreneurship will be developed as important dimensions. The importance of work for migrants and the use of social entrepreneurship to promote employability will be highlighted. Case studies will be presented to illustrate the contents of the module.

Go-To Module ⑤

The course offers opportunities to participate in various learning activities. As a learning community we all adhere to the course netiquette.

Course Facilitators

Module 1 Centre for Migration Health

Rolf Vårdal is a physiotherapist at CMH, Bergen, Norway. Working with refugees continuously since 1998, in clinical work from 1998-2009, and from 2015 until present. In-between work at the regional Resource Center on Violence, Traumatic Stress and Suicide Prevention from 2006-2015, and the local center for integration in Bergen as a councillor from 2010-2013, thus gaining experience in the process of inclusion and integration into a new society, seeing this from different perspectives.

Has extensive experience in work with survivors of torture, realizing the need for improving the level of knowledge and services required for rehabilitation. Has experience from work with vulnerable populations in Peru and Georgia in very adverse conditions compared to Norway. Apart from physiotherapy relevant studies in history, human rights monitoring and counselling. Contributions on conferences and seminars on different aspects of migration, lecturing also for students in various professions about the same topics.

Project experience from PREP and also project cooperation with ICAR Foundation on developing services for vulnerable migrants in Romania. He has been a volunteer at the Center for Undocumented Migrants in Bergen since 2014 and is also a council member of the International Society of Health and Human Rights.

Egil Kaberuka-Nielsen, the Head of the department at CMH, is an experienced leader, social worker, and migration health professional passionate about promoting the well-being of migrants and refugees. With extensive experience in the health and healthcare sector, he has held roles such as Refugee Health Coordinator, Coordinator for Children and Young People's Mental Health, and Environmental therapist in Bufetat (The Norwegian Children, youth and family directorate) while working in Bergen Municipality. He holds a university degree in Social Work with additional studies in health for immigrants, Organizations and Management.

With a solid foundation in healthcare coordination, social pedagogy, and child welfare, Egil brings to the table an understanding of public administration, organizational management, personnel management, project management, and economics. His particular interest lies in the integration-related field, specifically the link between integration and migration health.

Egil has given lectures at many different educational institutions on the topic of migration and many different lectures at seminars and conferences on refugee-related issues.

As the Centre for Migration Health leader in Bergen, Norway, Egil is committed to promoting the connection between integration and migration health. He believes that this is a crucial aspect of promoting the well-being of migrants and refugees. With his extensive experience in public management and health service for migrants, Egil can be an asset to migration health-related projects.

Huseyin Emlik is a researcher/sociologist who is actively engaged in research and project development, implementation, and data analysis at the Center for Migration and Health (CMH) in Bergen, Norway. He possesses significant research experience in various fields such as social trauma, oral history, local belief systems and rituals, gender, poverty, discourse analysis, discrimination, xenophobia, nationalism,

militarism, and racism. Furthermore, his research interests extend to political economy, racial division of labor, genocide, and massacre studies.

Drawing on his research expertise, Huseyin has served as both a project leader and project worker in numerous projects targeting victims of genocide and massacre, the impoverished, villagers, the disabled, drug addicts, and refugees since 2011 in Turkey, Norway, and Sri Lanka.

Huseyin's research since 2015 has focused specifically on conducting one-on-one and focus group interviews with refugees regarding their migration process, the traumatic experiences they encountered during the process, and coping strategies for these traumas. He has also conducted research on new adaptation strategies, changes in family and group roles based on gender, and the positive and negative impacts on family dynamics and group solidarity patterns in the countries where refugees migrated after fleeing their homes. Additionally, Huseyin has conducted field studies on the survival/pragmatic strategies and political preferences of refugees and has analyzed the strategic discourses they produce.

As a human rights activist/defender, Huseyin is a volunteer active member of a few human rights associations and the leader of the Kurdish Democratic Community Center-Bergen, Norway.

Aleksander Bergli, works at Center for Migration and Health (CMH) in Bergen, Norway. He has a bachelor's degree in Russian language an in Comparative Politics.

Module 2, Trinity College Dublin

Sarah Quinn has been an Assistant Professor in the Discipline of Occupational Therapy since 2002. Her current research interests are in the area of occupational science and social inclusion, feminism and mothering. She has a background in using both qualitative and quantitative methodologies with a particular interest in biographical narrative.

As an occupational therapist in clinical practice, Sarah worked with people across the lifespan and in a range of settings with both a physical and psychosocial focus. Most recently she has worked an occupational therapy service supporting students to participate academically and socially in college life.

While Sarah's current teaching focuses on occupation she has also taught a range of modules, including research methods and evidence-based practice. She coordinates a module on occupational justice and participatory citizenship in which she lectures on issues pertinent to refugee health and wellbeing. Sarah is the Faculty of Health Science's representative on the Civic Engagement Committee, the activities of which have supported the university to become a University of Sanctuary awarding scholarships to refugees to study at TCD.

Sarah has developed projects in a women's prison involving students as peer educators, forming collaborations between the prison and a community arts festival, and in so doing forwarding her particular interest in supporting wellbeing through participation. As coordinator of a community-based learning module, Sarah has developed partnerships with people who are socially or occupationally disadvantaged, including community organisations that represent refugees. This has fostered her particular interest in these partners' opportunities for engagement and participatory citizenship.

Emer McGowan is an Assistant Professor in Interprofessional Learning in the Faculty of Health Sciences in Trinity College Dublin. Dr McGowan's main research interests are refugee health, leadership in healthcare, health professional engagement and leadership development. Dr McGowan has a special interest in qualitative research methods.

Following her graduation in 2010 as a physiotherapist, she worked in a range of clinical physiotherapy roles in Ireland, the UK and New Zealand. She returned to Ireland in 2013 to begin PhD in Trinity College Dublin researching leadership in the profession of physiotherapy.

She was awarded her PhD in 2017 and completed her postdoctoral fellowship researching leadership and leadership development in healthcare at Trinity College Dublin. In 2019, Dr McGowan moved into the position of Assistant Professor in the Discipline of Physiotherapy in Trinity College Dublin. She was a member of the Physiotherapy and Refugee Education Project which developed an online education programme to prepare physiotherapists to work with people with refugee experience. From her involvement in this project, she has become very interested in improving health care experiences and access for refugees.

In her current role as Assistant Professor in Interprofessional Learning, Dr McGowan co-ordinates and facilitates interprofessional learning for students across disciplines in the Faculty of Health Sciences. She hopes that her experience on the Physiotherapy and Refugee Education Project and in her current role will enable her to make a valuable contribution to PREP-IP.

Module 3, Western Norway University of Applied Sciences

Merethe Hustoft, PhD and associate professor from the Department of health and functioning, Western Norway University of applied sciences. She teaches at the bachelor programme of occupational therapy and is the deputy leader for the Centre for interprofessional education (Senter for tverrprofesjonell samarbeidslæring: TVEPS). She is also working as a researcher at the Regional centre for habilitation and rehabilitation in Western Norway.

Her main research areas of interests are rehabilitation, continuity of care, interprofessional teams, promoting and inhibiting factors for sustainable interprofessional education and interprofessional mindset. Her research area also concerns long term changes after rehabilitation and health services research.

Merethe is a research group leader for the health promotion and rehabilitation group. She is an active participant and member of the PREP-IP Erasmus+ project.

Djenana Jalovcic, MPA, MSc, EdD is Associate Professor at the Department of Health and Functioning, Western Norway University of Applied Sciences where she coordinates the Master program in Healthy Ageing and Rehabilitation. She is an inclusive development practitioner, educator, and researcher.

Djenana has over 25 years of experience working with post-secondary institutions where she has led projects in disability, community based rehabilitation and inclusive development globally. She has in-depth knowledge of pedagogy, educational technologies, and online learning. She lives in Canada and teaches online in Norway. She has experience in instructional design and curriculum development of interprofessional graduate programs in health and social studies. She is a founding member of Women in

Global Health Canada and an active mentor in the MentorNet of the Canadian Association for Global Health.

Djenana is a coordinator of PREP IP and a team member in two other Erasmus+ projects: Health Equity through Education Project and Embracing a Complexity Orientated Learning Approach in Health.

Michel D. Landry is a Professor at the Western Norway University of Applied Sciences in Bergen, Norway, and an Adjunct Professor at the Duke Global Health Institute at Duke University in Durham, NC, USA. Prior to his current position, Dr. Landry spent several years as Professor and Division Chief of the Duke Doctor of Physical Therapy Division where he successfully led an important rebuilding of the program that has now grown into one of the top physical therapy programs in the United States.

Dr. Landry is a health policy and health services researcher, a Past-President of the Canadian Physiotherapy Association, a former Career Scientist at the Ontario Ministry of Health and Long-Term Care (MOHLTC) and has been a consultant to many global multilateral agencies including the World Health Organization. Mike lectures widely on the public policy and political dynamics of rehabilitation, and is a provocative and disruptive advocate for the moral, ethical, and economic necessity to ensure rehabilitation services across the continuum of high, middle, and low-income countries

Mohammad Ali Farhat, M.Sc. in Rehabilitation Science. Ali is a graduate of Bangladesh Health Professions institute (BHPI) under Faculty of Medicine, Dhaka University. In 2016, he got his bachelor's degree (B.A) from Department of Management, Faculty of Psychology and Educational Science at Kabul University of Afghanistan. For one year he worked as administration manager with Noyan group trading company.

In 2021, after receiving his master's degree from Bangladesh, he started to work as a psychological support supervisor, with Premiere Urgence- an international non-governmental medical aid organization in Afghanistan. Ali is currently working as a volunteer with persons with refugee experience education project- interprofessional (PREP-IP). He loves to work in the humanitarian field, especially with persons who are refugees and have mental health problems.

Independent Doctors Association

Esra Alagoz, I am from Gaziantep, Turkey. I'm a physiotherapist, graduated on 2018 and now a Master's Degree student in Neurology Physiotherapy at Hacettepe University in Ankara, Turkey. I've been in humanitarian work since 7 years, which includes volunteering and 3 years of professional work.

My interest in humanitarian work has started when we started receiving refugees in my city, which is very close to the border. Then I started to feel a responsibility to facilitate the things for these people, because none of them wanted to be in this situation. I started as translator and some other easy voluntary tasks in some organizations and then I started to work professionally in this work, which I still continue.

My main goal is to disseminate the experience I have aiming perhaps, humbly to inspire others. So that they can also do something and eventually we can build up a chain that would touch many many lives.

Module 4, HAWK University of Applied Sciences and Arts Hildesheim/Holzminden/Göttingen

Dr Sandra Schiller is a lecturer in the Bachelor and Master of Science Programme Occupational Therapy, Speech and Language Therapy and Physiotherapy and the Bachelor of Arts Programme Educational Sciences for Allied Health Professions, and International Coordinator at HAWK for Occupational Therapy, Speech and Language Therapy and Physiotherapy.

Her main teaching and research areas are Ethics and Diversity and International Communication.

Since 2008 Sandra Schiller has run several (interprofessional) projects on health promotion and health care information for refugees.

She is a founding member of the Occupational Therapy Europe Expert Group (now: Interest Group) on Displaced Persons and leader of the German Occupational Therapy Association's Working Group on Community Development, which is responsible for developing occupational therapy services for refugees outside the traditional healthcare sector.

Kathrin Weiß (MSc) is a lecturer in the Bachelor of Science Programme Occupational Therapy, Speech and Language Therapy and Physiotherapy and the Bachelor of Arts Programme Educational Sciences for Allied Health Professions, main teaching areas are Interprofessional Competencies for Health Professions and Professional (interprofessional) Reasoning.

Since 2009 member of the Network TATKRAFT – health promotion program for elderly people.

Module 5, Universitat de Vic - Universitat de Central Catalunya

Salvador Simó is a professor and researcher at the University of Vic - the Central University of Catalonia. He is currently the Associate Director of the Chair of Mental Health. He also coordinates the Innovation in Mental Health and Social Wellbeing research group. He is leading six PH students. His areas of interest are refugees, social determinants of mental health, social entrepreneurship, art and culture a new Technologies.

He has developed intervention projects on the ground with refugee communities in Bosnia, Guatemala and Kosovo working with Doctors Without Borders.

He has also participated in various European projects related to refugee communities such as Interdisciplinary cooperation for psychosocial interventions. A case study of refugees http://interact-erasmus.eu/. He has also led projects at the European level related to the well-being and social inclusion of people with special needs, especially people with mental health problems, immigrants, and people in situations of social exclusion. At a national level, he has led around twenty-five web n social participation projects.

International consultant and lecturer. He has taught at more than 20 universities abroad. He is the co-author of the best seller of Occupational Therapy Occupational Therapy without Borders (Elseviers). He has approximately 100 publications between articles, chapters, and books.

Portfolio https://www.salvadorsimo.org/?lang=en

salvador.simo@uvic.cat

Course netiquette

Here is our course netiquette: the guidelines for online behavior and interaction, with indication of what is expected and acceptable in our online classroom.

General guidelines

- treat everyone in the course with respect
- use clear, concise and grammatically correct language
- avoid use of slang and social media/texting abbreviations
- avoid use of CAPITAL LETTERS
- be cautious when using humor and sarcasm as your message might be taken seriously or as offensive due to the characteristics of the online media that relies on text without non-verbal cues and cultural differences of our multicultural class
- do not make personal comments in any communication
- safeguard personal information, yours and of your peers' and exercise caution when conveying confidential information

Discussions

- ensure that your posts are relevant, on topic, within the scope of the course material and follow the instructions given for the specific discussion
- be respectful of different opinions
- be respectful when disagreeing with peers expressing your different view in constructive way
- review and edit your contributions before posting them
- read the whole thread before posting to avoid repeating someone else's post
- acknowledge the source and give proper credit when referencing or quoting other people's work
- do not make personal or insulting remarks
- be open minded
- actively participate, actively listen, ask questions, provide answers, positive and constructive feedback

Adapted from the OSU Institute of Technology and Fanshawe College.

How to navigate the course

The PREP IP course "Interprofessional approach to refugee health" is a fully online, self-paced course that will be open for six months from November 2024 to April 2025. Please mote that there are no synchronous (live events). Asynchronous activities that can be completed at own time are not facilitated and may not be very active as they depend on the number of registered users studying at the same time. The organization of the course allows participants to explore the curated resources at their own time and pace.

The course is organized in five modules covering five specific topics. Learners can access modules from the course home page or by clicking on Modules in the left bar menu. Within the module, you can progress from topic to topic by pressing the Next button at the bottom of each page. You can also access each topic from the list of Modules.

Each module is organized in a similar way with the introduction that describes the module and topics in which you can find information about the topic, learning resources to read and watch, and learning activities. To assist with the course navigation, in each module we created a page with all learning resources organized in one place, along with a page with learning activities and assessment for that module.

Module 1

Introduction

This module aims to provide a general overview of the theoretical content related to refugees by highlighting the unique conditions that refugees experience. Additionally, the module will explore how healthcare professionals address the specific needs and challenges of refugees, all within the context of the basic human rights concept.

The module will cover key theoretical concepts, explore case studies, and offer practical guidance on providing adequate care to refugees. By the end of this module, learners will have gained a deeper understanding of the complex challenges facing refugees and the critical role that healthcare professionals play in meeting their unique needs.

A student who has completed the module:

- has knowledge of key terminology and concepts related to global migrations and refugees
- has understanding of the human rights of refugees
- can critically review country specific policy and legislation in the migration field to enhance their understanding of the life situation of people with refugee experience

Topics

- Global migrations
- Persons with refugee experiences
- Refugee rights are human rights
- Global health and refugee health

During this module learners will participate in different learning activities including:

- engaging with curated learning resources (watching videos, readings)
- completing the individual and group work (discussions, reflections)
- investigating relevant local policies and regulations related to refugees' human rights

Meet persons with refugee experiences

At the beginning of every module, we introduce you to persons with refugee experiences who shared their stories with various non-governmental organizations. We start with Refugees around the world: Stories of survival. compiled by Doctors without Borders.

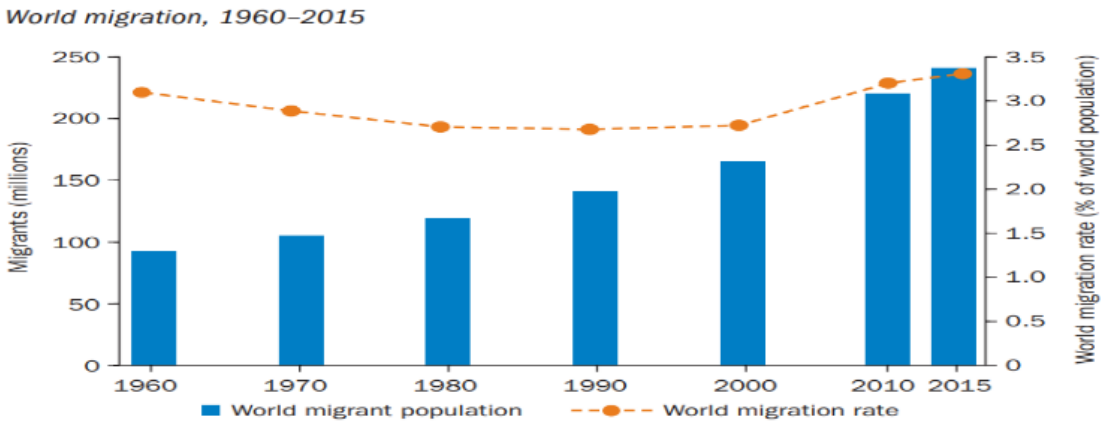
Global migrations

Migration

Global Context

Since the earliest times, migration has been an intrinsic part of human existence. People have migrated in pursuit of job opportunities, economic prospects, to reunite with loved ones, or to further their education. In some cases, they've been compelled to leave their homes to flee from war, oppression, acts of terror, or violations of basic human rights. Others relocate due to the detrimental impacts of climate change, natural calamities, or environmental challenges.

In the present day, more and more people reside in countries other than their birthplaces. The IOM World Migration Report 2020 states that, as of June 2019, there were nearly 272 million international migrants worldwide, an increase of 51 million compared to 2010. The majority, almost two-thirds, were labor migrants. International migrants made up 3.5% of the global population in 2019. International migrants have been a stable share of world population at roughly 3 % of world population. However, the absolute number of migrants has been rising with world population. However, these migrants are only a small share of people who would like to migrate. The Gallup World Poll show that 13% of world population would like to migrate. (UN)



Sources: Data from the World Bank Global Bilateral Migration Database (1960–2000) and the United Nations Global Migration Database (2010–15). Population data from United Nations World Population Prospects.

Migration, however, is not always a matter of choice; for many, it is a necessity. The UNHCR reports that, by the end of 2019, there were 79.5 million forcibly displaced individuals across the globe. Of these, 26 million were refugees (20.4 million under UNHCR's mandate and 5.6 million Palestine refugees under UNRWA's mandate). Additionally, 45.7 million people were internally displaced, 4.2 million sought asylum, and 3.6 million were Venezuelans displaced abroad.

Map of the total number of international migrants within each country.

Definition of a migrant:

The UN Migration Agency (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

- (4) what the length of the stay is

(Source: International Organization for Migration (IOM))

It is important to distinguish between migrant and refugee:

A 'migrant' is fundamentally different from a refugee. Refugees are forced to flee to save their lives or preserve their freedom, but 'migrant' describes any person who moves, usually across an international border, to join family members already abroad, to search for a livelihood, to escape a natural disaster, or for a range of other purposes. However, refugees and migrants often employ the same routes, modes of transport, and networks. Movements of both refugees and migrants are commonly referred to as 'mixed movements'. It is important to distinguish the different categories of person in mixed migratory movements and apply the appropriate framework of rights, responsibilities, and protection.

Migration Explained.

YouTube video 4 minutes long (includes subtitles)

What is Immigration Policy?.

YouTube video 3 minutes long (includes subtitles)

There are number of obstacles for understanding migration

- Disciplinary and methodological fragmentation (qualitative vs quantitative), e.g. political scientist, economist, sociologist, legal scholars all study migration study migration in a self-contained way
- Migration studies often tend to focus on receiving countries which often can create bias, e.g. the receiving country mainly focus on their own interests
- Shorty term focus - Policy makers often respond to public outrage or concern about certain issues which again reinforces the focus on issue or group. However, these short-term policies often fail or have limited effect.

What can this reveal?

- Limited understanding of the forces driving migration, this coincides the short-term focus
- Weak theoretical basis of migration studies: limited understanding of what drives migration processes, how are causes, consequences, origin and destination of migration interlinked
- It underlines the importance to detach research (and policies) from immediate concerns of policymakers and move towards fundamental understanding of migration

Migration Types

Literature presents us with different types of definitions:

1. Jennissen (2004), four main types of migration are identified, namely: 1) Labour migration; 2) Return migration; 3) Chain migration; and 4) Asylum migration. Labour migration is defined as cross-border movement for employment in another country. It involves high-skilled, semi-skilled

and unskilled migrants. If international migrants intend to return to their country of citizenship after living as international migrants in a foreign country and stay in their own country for at least a year, they are called as return migrants. Individuals who are moving from one country to another for family re-unification and family formation are considered as chain migrants. Asylum seekers who visit a foreign country seeking refugee status are considered as asylum migrants. (Wimalaratana 2017)

2. Bell, Alves, de Oliveira and Zuin (2010) identify three main types of international migration, namely: 1) Labour migration; 2) Forced migration; and 3) International retirement migration. Labour migration involves the migration of high-skilled, unskilled low wage, and temporary labour. Forced migration includes refugees and asylum seekers who cross borders due to conflicts and political uncertainties, and the displaced who have lost their settlements due to natural disasters and construction projects (Bell et al., 2010; Castles, 2003). International retirement migration is when the retired purchase property abroad for their residence (Bell et al., 2010). (Wimalaratana 2017)

3. The other common categorization in the literature is Forced and Voluntary migration (Hugo, 2008; Koppenberg, 2012; Zetter, 2015). People who move from one country to another as asylum seekers, refugees and internally displaced persons are considered as forced migrants, while others who move for different purposes, including those who supply labour are considered as voluntary migrants. The former group has no other option than migrating to a different country due to the struggles they face in their home country, but the latter voluntarily migrate in search of personal gains. (Wimalaratana 2017)

What are pros and cons of using such definition? Who is left out?

What drives individuals to migrate?

The process of international migration is often influenced by a combination of 'push' and 'pull' factors:

Push factors originate in the migrants' home country and contribute to their desire to relocate. For example, high unemployment rates, political instability, or limited educational opportunities may compel individuals to seek better prospects elsewhere. On the other hand, pull factors are associated with the destination country, or the host country, and serve as attractions for potential migrants. These factors may include higher wages, better living conditions, or greater access to quality healthcare and education.

For instance, a software engineer from a developing country may be driven to migrate to a tech hub like Silicon Valley due to limited job opportunities (push factor) in their home country and the potential for better career growth and compensation in the United States (pull factor).

Push factors

- Wars, conflict, political instability, and economic crisis
- Ethnic and religious persecution
- Natural and man-made disasters, such as earthquakes
- Poverty

- Unemployment, low wages and poor working conditions
- Shortages of food, water, or healthcare
- Limited opportunities

Pull factors

- Better quality of life and standard of living
- Varied employment opportunities, higher wages
- Better healthcare and access to education services
- Political stability, more freedom
- Better life prospects
- For retirees; a range of services to cater to their needs, or environmental characteristics, such as the coast.

https://youtu.be/fjKYtfpe1a0

YouTube video 10 minutes long (includes subtitles)

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- World Bank. 2018. *Moving for Prosperity: Global Migration and Labor Markets. Policy Research Report*. Washington, DC: World Bank. doi:10.1596/978-1-4648-1281-1. License: Creative Commons Attribution CC BY 3.0 IGO (Page 1-36)

Persons with refugee experiences

Migrants cross the Rio Bravo to turn themselves in to US Border Patrol agents to request asylum in El Paso, Texas, on December 11, 2022.

https://edition.cnn.com/2022/12/13/politics/immigration-border-mayorkas-what-matters/index.html

“Refugees are neither seen nor heard, but they are everywhere. They are witnesses to the most awful things that people can do to each other, and they become storytellers simply by existing. Refugees embody misery and suffering, and they force us to confront terrible chaos and evil.” (Helton, A. C. (2002). The price of indifference: Refugees and humanitarian action in the new century. OUP Oxford.)

Introduction

Persons with refugee experiences topic is designed to provide you with an understanding of the unique challenges faced by individuals who have been forced to flee their home countries due to persecution, conflict, or other forms of violence. The term "Persons with Refugee Experiences" refers to individuals who have been granted refugee status or asylum in a new country, as well as those who are still in the process of seeking protection.

In this inspiring TED talk, Luma Mufleh shares stories of hope and resilience as a person with refugee experiences. The video is from 2017, but it's just as relevant today.

https://youtu.be/6wNif5SlN08

Through this topic, you will gain a deeper understanding of the terminology, legal and policy frameworks that govern the protection of refugees, as well as the social, economic, and cultural factors that can impact their integration into new communities. We will explore the experiences of refugees from different regions of the world and discuss the ways in which cultural and linguistic diversity can enrich our understanding of global migration patterns.

Who is a refugee?

The use of terminology related to displacement, such as refugees, migrants, forced migration, and related concepts, can be challenging to differentiate. These terms are often used interchangeably, which can lead to confusion and misunderstandings. Thus, it is crucial to refer to authoritative sources to obtain a clear understanding of these terms and their distinctions. To achieve a nuanced comprehension of these concepts, extensive reading and research on the concepts of refugees, asylum seekers, immigrants, and migration are recommended. In brief, the term "refugees" is typically defined as individuals who flee war, violence, conflict, or persecution and seek safety in another country by crossing an international border.

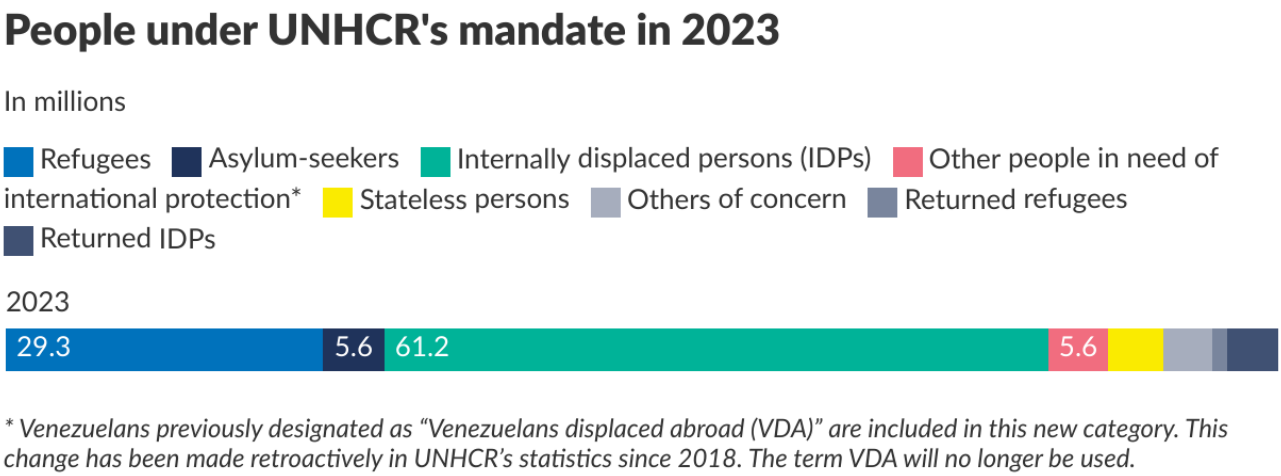
Read definition https://www.unrefugees.org/refugee-facts/what-is-a-refugee/

https://youtu.be/GvzZGplGbL8

What does it mean to be a refugee?

117.2 million people will be forcibly displaced or stateless in 2023, according to UNHCR's estimations. The majority have become Internally Displaced Persons, meaning they fled their homes but are still in their own countries. Others, referred to as refugees, sought shelter outside their own country. But what does that term really mean? To figure out that watch the video below.

Read definition https://www.unhcr.org/media/3-who-refugee-manual



Read the details https://reporting.unhcr.org/global-appeal-2023?page=10

https://youtu.be/25bwiSikRsI

The 1951 Convention relating to the Status of Refugees, commonly referred to as the Refugee Convention, holds significant importance in the realm of international law pertaining to refugees. The Convention provides a comprehensive framework that elucidates the legal status of refugees and delineates the rights and obligations of both refugees and the countries that have ratified the Convention. The Convention provides an explicit definition of who can be classified as a refugee and outlines the type of legal protection and social welfare entitlements that should be afforded to them by the host countries. These protections extend to safeguarding the rights of refugees, including their access to education, employment, and other social rights. Furthermore, the Convention provides specific guidance on the obligations of refugees towards host governments and establishes categories of individuals, such as war criminals, who do not qualify for refugee status.

Read more about the Refugee Convention https://www.unhcr.org/ie/media/convention-and-protocol-relating-status-refugees

The Dublin Regulation is a European Union (EU) law that sets out the criteria for determining which EU country is responsible for examining the asylum application of a person who has applied for international protection in one of the EU Member States. It is designed to ensure that asylum seekers are not able to "shop around" for the most favorable country to make their application. The regulation applies to all EU Member States, as well as Iceland, Norway, and Lichtenstein. According to the regulation, the first country an asylum seeker enters is responsible for processing their application for asylum. The purpose of this rule is to prevent so-called "asylum shopping" where people move from one country to another in search of better conditions and welfare benefits

Read more about the Dublin Regulations https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:02013R0604-20130629

Watch this video to get a better understanding of the Dublin Regulation:

https://youtu.be/ZEgezPFtm-k

The 1st World Congress on Migration, Ethnicity, Race and Health in Edinburgh in May 2018 resulted in the Edinburgh Declaration. The Declaration calls for meaningful action and dialogue among researchers and healthcare personnel to address the health needs of marginalized populations, including indigenous and Roma peoples. The Declaration emphasizes the importance of addressing social determinants of health and cultural competency among healthcare professionals. It also highlights the need for increased research efforts and policy guided by principles of equity, social justice, and human rights. The Edinburgh Declaration is an important milestone towards achieving health equity and addressing complex health challenges faced by marginalized populations.

Read what the Edinburgh Declaration (external link).

What are the refugees' experiences?

Being a refugee occurs throughout a process such as all other social phenomena. Mostly refugees may experience imprisonment, violence, torture, sexual violence, death threat, etc. before forced to flee from their host countries. “During flight, refugees are frequently separated from family members, robbed, forced to inflict pain or kill, witness torture or killing, and/or lose close family members or friends and endure extremely harsh environmental conditions.”

The experiences of asylum seekers and refugees are multifaceted and intricate and are shaped by numerous factors such as the individual's characteristics, group dynamics, country of origin, country of destination, local population, policy environment, and so forth. Despite the wide range of factors influencing these experiences, a substantial corpus of research has been dedicated to exploring and comprehending the experiences of refugees and asylum seekers, with the aim of enhancing these experiences and understanding the impact of various policies on their outcomes.

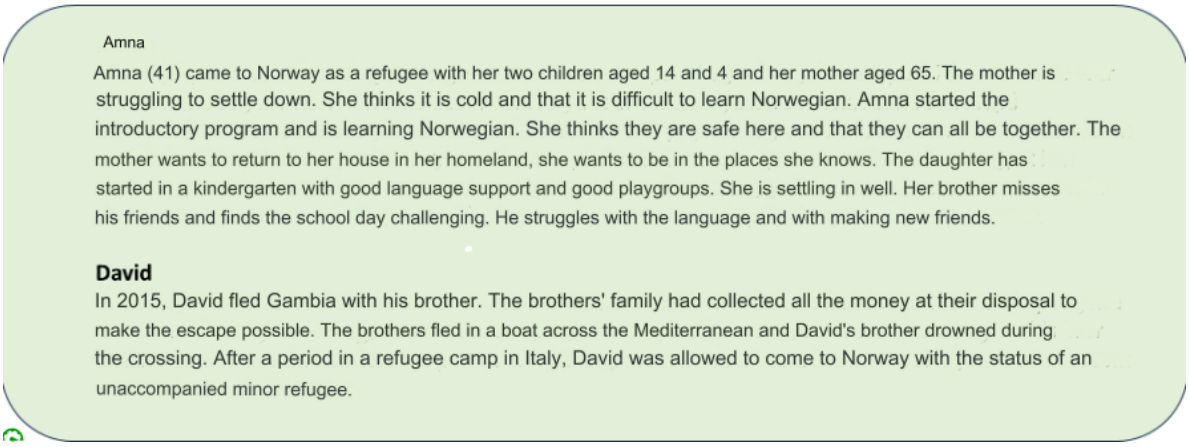
Read the definition.

Video by Global Citizen: I am a refugee: Global refugees share their stories
https://www.youtube.com/watch?v=8bEK6gytwec

https://www.youtube.com/watch?v=7P0iP2Zm6a4

https://youtu.be/7P0iP2Zm6a4

What do you think about how the migration process can affect a person?
Here you can read about Amna and David, how do you see their situation in Norway and how do you think the situation they are in affects them?



Amna

Amna (41) came to Norway as a refugee with her two children aged 14 and 4 and her mother aged 65. The mother is struggling to settle down. She thinks it is cold and that it is difficult to learn Norwegian. Amna started the introductory program and is learning Norwegian. She thinks they are safe here and that they can all be together. The mother wants to return to her house in her homeland, she wants to be in the places she knows. The daughter has started in a kindergarten with good language support and good playgroups. She is settling in well. Her brother misses his friends and finds the school day challenging. He struggles with the language and with making new friends.

David

In 2015, David fled Gambia with his brother. The brothers' family had collected all the money at their disposal to make the escape possible. The brothers fled in a boat across the Mediterranean and David's brother drowned during the crossing. After a period in a refugee camp in Italy, David was allowed to come to Norway with the status of an unaccompanied minor refugee.

Recommend Readings

1. Bozorgmehr, K., Schneider, C., & Joos, S. (2015). Equity in access to health care among asylum seekers in Germany: evidence from an exploratory population-based cross-sectional study BMC health services research, 15, 1-12.
2. Harris, R., Tobias, M., Jeffreys, M., Waldegrave, K., Karlsen, S., & Nazroo, J. (2006). Racism and health: The relationship between experience of racial discrimination and health in New Zealand Social science & medicine, 63(6), 1428-1441.
3. Mangrio, E., & Sjögren Forss, K. (2017). Refugees' experiences of healthcare in the host country A scoping review BMC health services research, 17(1), 1-16.

4. Næss, A. (2020). Migration, gender roles, and mental illness The case of Somali immigrants in Norway International Migration Review, 54(3), 740-764.

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1. Mufleh, Lume (02,09 2023). TEDed- Obtained from Don`t feel sorry for refugees - believe in them: Luma Mufleh: Don't feel sorry for refugees -- believe in them | TED Talk.

2. Benedetta Berti, E. B. (10, 03 2023). *TEDEd*. Obtained from What does it mean to be a refugee?: https://ed.ted.com/lessons/what-does-it-mean-to-be-a-refugee-benedetta-berti-and-evelien-borgman.

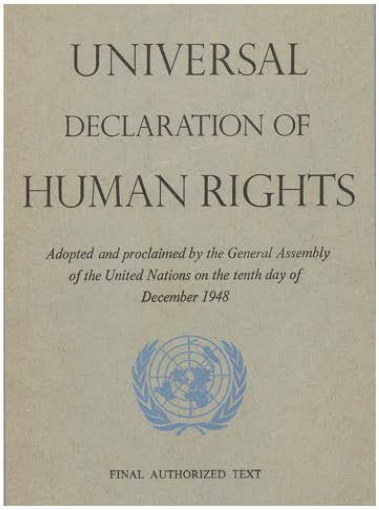
3. ... (2023, 02 10). Y*outube*. Obtained from AsylEasy: Dublin Regulation: https://www.youtube.com/watch?v=ZEgezPFtm-k

4. ... (2023, 02 10). *Youtube*. Obtained from KCET: Immigration 101: Refugees, Migrants, Asylum Seekers - What's the Difference?: https://www.youtube.com/watch?v=CGftwNQ_LXI

5. ... (2023, 02 12). *Youtube*. Obtained from Global Citizen: I AM A REFUGEE: Global refugees share their stories: https://www.youtube.com/watch?v=8bEK6gytwec

6. ... (2023, 02 24). *Youtube*. Obtained from CrashCourse: Prejudice and Discrimination: Crash Course Psychology: https://www.youtube.com/watch?v=7P0iP2Zm6a4&t=57s

Refugee rights are human rights



Article 1

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Introduction

In this topic we discuss human rights of refugees. This is an opportunity to explore human rights, gain deeper understanding of human rights instruments and consider using of the rights based approach to support refugees in a specific country context. 2023 is the year when we mark the 75th anniversary of the Universal Declaration of Human Rights, that is as relevant today as it was 75 years ago.

What are human rights?

Human rights are the rights that belong to all human beings regardless of sex, age, race, ability, color, language, religion or conviction, political or other opinion, national, ethnic or social origin, nationality, economic position, property, marital status, birth or other status. Human rights are:

- universal - everyone is born with the same rights, equal and free, every human being is a right-holder
- inalienable - human rights can never be taken away
- indivisible, interdependent and interrelated - all rights are equally important, there is no hierarchy of rights, and no right can be fully enjoyed separately from other rights

In the aftermath of the Second World War, the Universal Declaration of Human Rights. was passed to provide the universal protection of fundamental human rights in situations of peace and conflict and to set a standard for all states and people. The Declaration is the foundation for other international and national human rights laws such as the International Covenant on Economic, Social and Cultural Rights. (came into force in 1976), and the International Covenant on Civil and Political Rights. (entered into force in 1976). These international human rights legal instruments are important as they identify States as duty-bearers responsible for respecting, protecting and fulfilling the human rights of individual right-holders. Article 14 of the Declaration asserts the right of individuals to seek and enjoy asylum:

1. Everyone has the right to seek and to enjoy in other countries asylum from persecution.
2. This right may not be invoked in the case of persecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

The right to health is a human right

The World Health Organization Constitution. (1946) recognized health as a human right "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." The right to health is a fundamental human right of all people including refugees. The right to health is part of many international legal instruments (e.g. International Covenant on Economic, Social and Cultural Rights., Convention on the Rights of Persons with Disabilities). that are introduced to protect human rights of specific groups as the general instruments did not sufficiently protected them (e.g. refugees, persons with disabilities, etc.).

Read the article 'The Highest Attainable Standard': The Right to Health for Refugees with Disabilities

to learn more about the compounding effect of the intersection between being a refugee and having a disability on the right to health of refugees with disabilities.

Who protects human rights of refugees?

The Universal Declaration of Human Rights protects and promotes the human rights of all people and governments are responsible for ensuring them. However, millions of refugees who were forced to flee their countries during the Second World War were in extremely vulnerable position as States were primarily responsible for protecting the rights of their citizens. An international legal instrument was necessary to address the global refugee problem and grant refugees the protection they needed to live the life in dignity and rights. Therefore, Convention and Protocol Relating to the Status of Refugees

were passed in 1951, and 1967 respectively. The Convention and the protocol are the legal basis for protecting the rights of refugees. They clearly state the rights of refugees and responsibilities of State Parties to protect them.

The Convention defines who is a refugee, and describes the rights and responsibilities of refugees, as well as responsibilities of State Parties in protecting the rights. One of the key principles is spelled out in Article 33. Prohibition of expulsion or return ("refoulement") that prohibits states from expelling or returning refugees to the borders of territories where their lives or freedom are threatened.

There are 149 State Parties to the Convention. The Convention calls for solidarity and sharing of responsibilities among duty-bearers so that the burden of resettling refugees are not carried by a small number of countries. Currently, 85% of refugees are hosted in low- and middle-income countries. UNHCR is the guardian of the Convention, however, there is neither body that monitors its implementation and nor a mechanism for individuals to file the complaints when the Convention rights are violated. As the global migration crisis is growing, many State Parties are interpreting the Convention in a more restrictive way. The crisis has brought forward very polarizing political views and anti-migration politics. Many countries in the Global North have introduced policies that block or deter movement of refugees and asylum seekers by framing the global migration crisis as a security issue rather than a human right issue and favoring restrictions over protection.

While critics call for reconsideration of the Convention as it does not address the current global migration crisis, UNHCR emphasizes that the Convention is still relevant and the cornerstone of refugee protection globally.

In 2018 the United Nations General Assembly passed the Global Compact on Refugees., a global framework that has four main objectives:

- Ease the pressures on host countries
- Enhance refugee self-reliance
- Expand access to third-country solutions
- Support conditions in countries of origin for return in safety and dignity

Human rights of refugees and the politics of the day

Some media reports, such as the Reuters article Denying refugees and migrants healthcare violates rights, WHO says highlight the human rights of refugees and their violations. However, the policies in different countries vary. One of the tools that can help us understand the policies related to migration is the Migrant Integration Policy Index (MIPEX)that measures policies to integrate migrants in countries using 58 indicators.

Join the discussion about the implementation of the Convention globally and human rights of refugees including their right to health. Post your response to the following questions: Is your country a signatory of the Convention Relating to the Status of Refugees? How is the Convention interpreted in your country and reflected in its current laws, regulations and policies? What is your view about how your country and legislation and policies related to the rights of refugees including their right to health?

Readings

Smith-Khan, L., & Crock, M. (2019). 'The highest attainable standard': The right to health for refugees with disabilities. *Societies*, *9*(2), 33.

UN General Assembly. (2018). Global Compact on Refugees,

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Global health and refugee health

Introduction

There are many ways that people and organizations have conceptualized 'Global Health,' and recently, Chen et al. have clarified and redefined many such meanings and misconceptions. Nevertheless, the World Consortium of Universities for Global Health reported that Global health is “a field of study, research and practice that places a priority on achieving equity in health for all people.” (https://globalhealth.duke.edu/what-global-health)

A key concept across all definitions of Global Health is 'Health Equity', which is more fully discussed elsewhere in this course. The Center for Disease Control and Prevention (CDC) in the United States defines Health Equity as a "... state in which everyone has a fair and just opportunity to attain their highest level of health." As such, Global Health and Health Equity concepts are entirely related to the structure, process, and outcomes of People with Refugee Experience. While the intersectionality of Global Health, Health Equity and Refugee Health is not always well defined, understood, or acknowledge, in this course, we interpret the trajectory of many Persons with Refugee Experience who experience disproportional health-related outcomes is fully positioned at this intersection.

Global Health and Refugee Health

The World Health Organization (WHO) has recognized this intersectionality, as evidenced by a portion of their website dedicated to 'Refugee and Migrant Health" (https://www.who.int/health-topics/refugee-and-migrant-health#tab=tab_3). On this website, you can locate significant information on Global Health and Refugee health. In particular, the drop-down tabs on the far left side of the website link above.

In 2021, the WHO launched an online course called "Global School on Refugee and Migrant Health.' Below we have linked the course introduction from Dr. Tedros (WHO Director-General), but we encourage you to explore the many field reports from Guatemala, Jordan, Serbia, and Bangladesh, as well as the online recordings from the 5-day course, which includes topics ranging from financing health care for Refugees to Public Health and Covid-19.

https://www.youtube.com/watch?v=J2p-oOuNyrM

(video is under 2 mins)

Below you will find the topics and the recordings (taken from the WHO website - see below) that are publicly accessible and provide a comprehensive perspective of Global Health and Refugee Health. You will notice the duration of each daily video below, and while it is not mandatory to review the entire duration for all videos, each contains excellent and relevant information for each learner to prioritize based on their interests.

- **Day 1: Refugee- and migrant-sensitive health systems** - **Video recording** (duration 1:39:20 mins)
- **Day 2: Public health and migration during COVID-19 pandemic** - **Video recording** (duration 2:07:59 mins)
- **Day 3: Public health aspects of mental health among refugees and migrants** - **Video recording** (duration 1:37:39 mins)
- **Day 4: Health promotion to improve the health and well-being of refugees and migrants** - **Video recording** (duration 1:38:16 mins)

- **Day 5: Financing health care for refugees and migrants** - **Video recording (duration 1:47:04 mins)**

Discussion/Learning Activity

In 2020, several colleagues involved in delivering this course published a paper called "R*efugee and Rehabilitation: Our Fight Against the 'Globalization of Indifference,*" (Landry et al., 2020), where we argued the importance of the intersectionality mentioned above. Several other arguments were made/positioned in this paper, and as a learning activity for this module, we have created an assignment that asks you to (1) individually read/critique the paper, (2) identify a key argument from the paper shows the intersectionality between Global Health, Health Equity and Refugee Health, and (3) express in about 200-300 words an opinion on this intersectionality. For this short assignment, you may agree or disagree with anything you read in the paper, or you can introduce new ideas/concepts based on something you read.

Key references

1. Chen, X., Li, H., Lucero-Prisno, D. E., Abdullah, A. S., Huang, J., Laurence, C., ... & Zou, Y. (2020). What is global health? Key concepts and clarification of misperceptions. *Global health research and policy*, *5*(1), 1-8.

2. Landry, M. D., van Wijchen, J., Jalovcic, D., Boström, C., Pettersson, A., & Alme, M. N. (2020). Refugees and Rehabilitation: Our Fight against the "Globalization of Indifference" Download Refugees and Rehabilitation: Our Fight against the "Globalization of Indifference". *Archives of Physical Medicine and Rehabilitation*, *101*(1), 168-170.

3. Onarheim, K. H., & Rached, D. H. (2020). Searching for accountability: can the WHO global action plan for refugees and migrants deliver? Download Searching for accountability: can the WHO global action plan for refugees and migrants deliver?. *BMJ Global Health*, *5*(6), e002095.

Module 1 Learning resources

Global Migrations

1. Bell, S., Alves, S., de Oliveira, E. S., & Zuin, A. (2010). Migration and land use change in Europe: A review. *Living Reviews in Landscape Research, 4*(2), 1-49.

2. Jennissen, R. P. W. (2004). *Macro-economic determinants of international migration in Europe*. Amsterdam: Rozenberg
Publishers

3. United Nations Department of Economic and Social Affairs, Population Division (2020). International migration 2020 highlights (ST/ESA/SER. A/452). This report is available in electronic format on the Division's website at www.unpopulation.org. (Page: 19-50)

4. Urbanski, M. (2022). Comparing push and pull factors affecting migration. *Economies,10(*21). https://doi.org/10.3390/ economies10010021

5. Wimalaratana, W. (2017). International migration and migration theories. *Social Affairs,1*. (Link: https://www.socialaffairsjournal.com/images/Journal_Downloads/Archives/2016_Fall/2.International-Migration-and-Migration-Theories_A.A.I.N.Wickramasinghe_W.-Wimalaratane_SAJ-15.pdf?type=file).

6. World Bank. 2018. *Moving for Prosperity: Global Migration and Labor Markets. Policy Research Report*. Washington, DC: World Bank. doi:10.1596/978-1-4648-1281-1. License: Creative Commons Attribution CC BY 3.0 IGO (Page 1-36)

Persons with Refugee Experiences

1. Bozorgmehr, K., Schneider, C., & Joos, S. (2015). Equity in access to health care among asylum seekers in Germany: evidence from an exploratory population-based cross-sectional study. BMC health services research, 15, 1-12.

2. Harris, R., Tobias, M., Jeffreys, M., Waldegrave, K., Karlsen, S., & Nazroo, J. (2006). Racism and health: The relationship between experience of racial discrimination and health in New Zealand. Social science & medicine, 63(6), 1428-1441.

3. Mangrio, E., & Sjögren Forss, K. (2017). Refugees' experiences of healthcare in the host country A scoping review. BMC health services research, 17(1), 1-16.

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5. ... (2023, 02 10). *Refugee and Asylum Seeker Experiences in their Host Country*. Hentet fra Pen state collage of earth and mineral sciences: https://www.e-education.psu.edu/geog571/node/447

Video References:

6. Benedetta Berti, E. B. (10, 03 2023). *TEDEd*. Obtained from What does it mean to be a refugee?: https://ed.ted.com/lessons/what-does-it-mean-to-be-a-refugee-benedetta-berti-and-evelien-borgman

7. ... (2023, 02 10). Y*outube*. Obtained from AsylEasy: Dublin Regulation: https://www.youtube.com/watch?v=ZEgezPFtm-k

8. ... (2023, 02 10). *Youtube*. Obtained from KCET: Immigration 101: Refugees, Migrants, Asylum Seekers - What's the Difference?: https://www.youtube.com/watch?v=CGftwNQ_LXI

9. ... (2023, 02 12). *Youtube*. Obtained from Global Citizen: I AM A REFUGEE: Global refugees share their stories: https://www.youtube.com/watch?v=8bEK6gytwec

10. ... (2023, 02 24). *Youtube*. Obtained from CrashCourse: Prejudice and Discrimination: Crash Course Psychology: https://www.youtube.com/watch?v=7P0iP2Zm6a4&t=57s

Refugee Rights are Human Rights

1. Smith-Khan, L., & Crock, M. (2019). 'The highest attainable standard': The right to health for refugees with disabilities. *Societies*, *9*(2), 33.

2. UN General Assembly. (2018). Global Compact on Refugees,
3. UN General Assembly. (2006). *Convention on the Rights of Persons with Disabilities.*
4. UN General Assembly. (1951, 1967). *Convention and Protocol Relating to the Status of Refugees.*
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1. Chen, X., Li, H., Lucero-Prisno, D. E., Abdullah, A. S., Huang, J., Laurence, C., ... & Zou, Y. (2020). What is global health? Key concepts and clarification of misperceptions. *Global health research and policy*, *5*(1), 1-8.
2. Landry, M. D., van Wijchen, J., Jalovcic, D., Boström, C., Pettersson, A., & Alme, M. N. (2020). Refugees and Rehabilitation: Our Fight against the "Globalization of Indifference" Download Refugees and Rehabilitation: Our Fight against the "Globalization of Indifference". *Archives of Physical Medicine and Rehabilitation*, *101*(1), 168-170.
3. Onarheim, K. H., & Rached, D. H. (2020). Searching for accountability: can the WHO global action plan for refugees and migrants deliver? Download Searching for accountability: can the WHO global action plan for refugees and migrants deliver?. *BMJ Global Health*, *5*(6), e002095.

Module 1 Learning activities and assessment

Asynchronous discussions:

Modul 1: The Convention and its implementation globally

Module assessment

This self-assessment is designed to test your understanding of the topic "Persons with Refugee Experiences." The assessment will consist of multiple-choice and/or short-answer questions. The questions will cover topics such as the definition of a refugee, the legal and policy frameworks that govern the protection of refugees, the experiences of refugees from different regions of the world, and the social, economic, and cultural factors that can impact their integration into new communities. The assessment will also include questions related to terminology used in the context of displacement, such as refugees, migrants, forced migration, and related concepts. The goal of this assessment is to help you identify areas where you may need further study or clarification. Answer the following self-assessment questions:

Module 1: Quiz (instructure.com)

Module 2

Introduction

This module will focus on exploring and recognizing the individuality and unique narratives of people with refugee experience. It will cover strategies that health and social care professionals can use to identify and respond to the specific needs and preferences of people using their services. The module will highlight the importance of continual learning in this area of practice and how critical reflection and appraisal of one's practice and outcomes are key components to ensure effective practice now and in the future. The concept of person-centered practice is explored and how this approach can be practically implemented by different professions working collaboratively in providing services for people with refugee experience. Related to this, the module will address building a relationship with service-users and recognizing the needs of those with refugee experience. Approaches to creating therapeutic space will be covered, again with emphasis on ensuring person-centered care.

As well as focusing on the person-centered approach to health and social care, this module will also emphasize the importance of demonstrating evidence-informed practice and integrating practice with research. Methods for keeping up to date with current research and best practice standards will be covered. Finally, in taking a whole-person approach to providing health and social care, the module will explore interaction and mutual learning between local and refugee communities and ways that this can be implemented. Examples of how better integration of people with refugee experience into the local community can be supported and how they are beneficial for both communities will be examined.

A student who has completed the module:

- has knowledge and understanding of the concept of person-centered care and how to incorporate it into their clinical practice working with people with refugee experience.
- has understanding of the importance of promoting better interaction and integration between the local and refugee communities.
- can critically appraise and review different sources of information, including that derived from the service-users' experiences and narrative, and synthesise evidence to inform their clinical practice working with people with refugee experience.
- can employ a range of strategies to create therapeutic space and to build a therapeutic alliance with people with refugee experience demonstrating appreciation for their unique needs.
- can appraise their current practice in their work environment and take action to implement strategies to improve delivery of person-centered care for people with refugee experience.

Topics

- Learning and critical reflection
- People-centeredness
- Relationship with, and recognition of the needs of patients
- Creating therapeutic space

- Integrating practice with research/Evidence informed practice/CPD and adoption of best practice standards
- Promoting interaction and mutual learning between local/refugee community

During this module learners will participate in different learning activities including:

- engaging with curated learning resources (watching videos, readings, sourcing and critically appraising literature)
- completing the individual and group work (discussions, reflection, peer review/feedback)
- case studies and clinical examples
- investigating relevant organisations/community sources of support in their locality

Meet persons with refugee experiences

[I AM A REFUGEE: Global refugees share their stories (youtube.com)]

People-centeredness

Photograph ©Independent Doctors Association (IDA)

People-centred care:

The health needs of refugees and the barriers and challenges that can prevent them from accessing health and social care differ from those of the host population over the life-course (WHO, 2021). Health and social care professionals can play a significant role in supporting the resettlement of refugees. Taking a person- or people-centred approach is central to this aim. Adaptable, well-trained and culturally competent health and social care workers are needed to provide services that are responsive to the unique health requirements of refugees (WHO, 2021). Provision of person-centred care can help to build trust between health professionals and refugees, both at the time of arrival and more importantly during longer-term refugee settlement (Procter, 2016).

A person-centred approach is concerned with human connectedness: the capacity for thought and feeling to be received, and lives to be revealed (Procter, 2016). When working with refugees, person-centred care will involve:

- Being open to the way a person explains, understands or interprets her or his or someone else's health problems or illness.

- Taking into account a person's cultural beliefs and understanding that these will influence the way in which symptoms are presented
- Considering the person's understanding of health difficulties and becoming aware of differently perceived causes of illness or disease, optimal care and culturally appropriate support and treatment.

The clinical work of any health or social care professional–no matter how willing or keen to help–will be compromised if they do not consider ways to ensure they take a person-centred approach.

https://youtu.be/pj-AvTOdk2Q

To further your understanding of people-centred care please read Compassionate care provision An immense need during the refugee crisis Lessons learned from a European capacity-building project by Mechili et al. (2018) which reports on a proposed model for refugee care with an emphasis on compassionate care. The paper outlines potential barriers and solutions for providing compassionate care.

Reflective activity:

Reflect on your own experiences of providing compassionate and person-centred care. Choose a specific example and explain how you adapted your approach to foster person-centred and compassionate care. Include any barriers or challenges you experienced in taking this approach and outline how you addressed them.

References:

Procter N (2016) Person-centred care for people of refugee background. J Pharm Pract Res, 46: 103-104. https://doi.org/10.1002/jppr.1222

World Health Organisation (2021) WHO releases two publications to promote people-centred health services for refugees and migrants. Available from: https://www.who.int/news/item/21-10-2021-who-releases-two-publications-to-promote-people-centred-health-services-for-refugees-and-migrants

Learning through critical reflection

Learning through critical reflection, and its importance in clinical practice, is the focus of this topic within Module 2. Reflection allows us to think back over events.

Reflection is the process of having an experience and then thinking back over observations, questioning actions, and reviewing the situation. It is an internal process that helps refine our understanding of an experience, which may lead to changes in our perspective. Reflecting upon our experiences is a very important part of the learning process. Critical reflection contributes to conceptual understanding and has the power to transform experiences into meaningful learning. To reflect critically involves more than pausing, thinking back over events, problem solving and planning future practice based on what we already know and how we already do things. Additionally, it demands critically questioning the content, process, and premise underlying the experience to make better sense of what has happened and reach a better understanding of the experience. When we reflect on our experiences in clinical practice, we take the opportunity to identify what was good and bad about what happened, query why things happened

as they did, and learn from this so that we can improve our future practice. Reflection can give meaning to experience; turn experience into practice, link past and present experiences and prepare us for future practice.

In short, "critical reflection is the process of thinking back on an experience to understand its meaning. It is often part of a learning process, where one reflects back to clarify and understand what has been learned and consider its importance. The process can often lead to some action, such as changing assumptions, seeking additional knowledge, or establishing a new course of action." (Ungvarsky, 2023).

Why practice the skill of critical reflection:

1. It encourages independent learning.
2. It helps order our thoughts and problem solve.
3. It helps achieve deep as opposed to surface learning.
4. It helps identify our personal strengths and areas for development.
5. It helps challenge our assumptions and recognise multiple perspectives.
6. It helps in exploring new ways of doing or thinking about things.

How critical reflection works:

Reflection helps to improve self-awareness and encourage critical thinking (Boyle-Baise & Langford, 2004; Maurasse, 2001). This in turn strengthens our ability to learn (Ehrlich, 1996). By linking concrete real-world experiences to professional knowledge, it helps us make sense of practice situations.

Theorists (e.g. Brookfield; Schon; Kolb; Gibb; Mezirow) have each emphasised aspects of the reflection process they consider important and developed methods of reflecting that encourage analysis of experiences to enhance learning. For instance, Schon emphasises Reflection-in-Action and Reflection-on Action. Reflection-**in**-action encourages us to think about what is happening during the interaction or event - thoughts, feelings, decisions, actions, consequences, and meaning. Reflection-**on**-action encourages us to consider the events at a later time, allowing time to process experiences, feelings and actions while taking into account new information and an opportunity to link the experience theory/knowledge. Brookfield's reflective theory requires the identification of significant events within an interaction or experience; encourages us to think about what happened in the event, our feelings, thoughts and actions during the event, what we did after the event, and our learning from that event.

Brookfield also recommends accessing different perspectives and questioning our assumptions. While Gibbs highlights the importance of identifying other possible behaviour/action choices.

To further your understanding...

Please read the following paper by Redfern and Bennet which describes a culturally appropriate critical reflective model developed to use when working with First Nation peoples of Australia (see Figure 1 below). It emphasises the importance of identifying the professional's privilege and reflecting from the perspective of both Western and Aboriginal ways of knowing, being and doing.

Redfern, H., & Bennett, B. (2022). An intercultural critical reflection model. *Journal of Social Work Practice*, *36*(2), 135–147. https://doi-org.elib.tcd.ie/10.1080/02650533.2022.2067139

Practicing critical reflection:

The following presentation describes an event that was reflected on to a basic level and gives pointers as to how the depth of reflection might be improved. It introduces the idea of considering micro to macro level factors that influence situations and emphasises the importance of considering events from a interprofessional perspective.

The questions below will help you be more critical in your reflection on your interprofessional practice:

https://hvl.instructure.com/courses/27587/files/2667907/preview

Remember, the basic elements or steps in critically reflecting on experiences or events are:

Thoughts – Feelings – Actions – Learning – PRACTICE PLAN

Critical reflection activity:

Use your reflective writing skills to describe and critically appraise how a person from a refugee community might experience your health/social care work setting. Select three events (points of contact by the person with your work setting), ideally ones in which you were present.

Appraise each event in turn by:

1. explaining the **context** of the events, providing an objective account of each,

2. identifying your **thoughts, feelings & behaviours**,
3. recognising **multiple perspectives** & influence of **cultural factors**,
4. evaluating the **learning** you have gained,
5. considering what might be **done differently or repeated** in the future.

Remember:

- Ask yourself questions as you reflect that challenge your values, beliefs and habitual ways of thinking and behaving.
- Be succinct. Use writing to help you decipher your learning but synopsize this before including it in your reflective report.

Reading:

Fook, J., & Gardner, F. (2013). Critical reflection in context: Applications in health and social care. Routledge.

Mezirow, J. (2003). How critical reflection triggers transformative learning. *Adult and Continuing Education: Teaching, learning and research*, *4*, 199-213.

Redfern, H., & Bennett, B. (2022). An intercultural critical reflection model. *Journal of Social Work Practice*, *36*(2), 135–147. https://doi-org.elib.tcd.ie/10.1080/02650533.2022.2067139

Rolfe, G., Jasper, M., & Freshwater, D. (2011). Critical reflection in practice: Generating knowledge for care. Palgrave Mac Millan.

Relationship with, and recognition of the needs of service-users

Explore Khaled's story from the Swedish Red Cross:

This video focuses on a detailed case study which provides an example of the ways that health professionals can attend to a person's narrative/story, better recognise the needs of people with refugee experience and thus respond to and address them in their approach.

https://youtu.be/ug_WEkXeOSo

Khaled

Watch Khaled's story from the Swedish Red Cross which describes the case study of a man from Syria, who has been granted international protection in Sweden. The video details the care and treatment provided to Khaled by a physiotherapist and psychologist. To connect more meaningfully with Khaled's experience try to:

- Identify ways that the physiotherapist and psychologist in the case study modified their practice in response to Khaled's needs.
- Think of any other ways that Khaled's individual needs could be identified, recognized and addressed?

- Consider what an interprofessional team working collaboratively with Khaled might bring and how together they might enhance Khaled's wellbeing.

To further your understanding...

Read the paper by Trimboli and Taylor (2016) Addressing the occupational needs of refugees and asylum seekers which discusses meeting the occupational needs of refugees and asylum seekers. Write three important points you have taken from reading this paper and outline how they will inform your future practice.

Discussion Board Activity:

Find a published article from your profession that provides an example of recognizing and meeting the needs of patients/clients/service-users. Post the article citation and underneath write three take-home messages from the article (max 200 words) in this discussion board - Module 2: Relationship with, and recognition of the needs of service-users. Each student should comment on at least one other student's discussion board post.

Creating therapeutic space

First and foremost, therapeutic space in this context occurs between two human beings, sometimes three, due to the presence of an interpreter. It involves one person defined as or having the role of a professional health/social care worker and another defined as or having the role of a patient/service-user. The interpreter when present physically or digitally, is regarded as a neutral entity, merely transmitting information between the two other individuals. However, it is essential to emphasize that the interpreter is also a human being whose presence can influence the relationship in various ways. Taking this into consideration, the focus will primarily be on the space between "therapist" and "patient." The quotation marks here are intentional and will be used invisibly throughout the text.

When working with refugees, some factors can create connection, while others may create distance. In the host country, the therapist likely resides permanently and generally has a sense of stability and safety that the refugee may not have established. Additionally, the therapist holds a certain power in this relationship, which one should be conscious of. The power dynamic stems from the therapists' authority due to their profession, representing a service, or even a state, where the patients might feel inferior due to the imbalance in roles. The patient has a health issue, either physical or psychological, or both, and seeks or expects help from the therapist.

It is therefore important to assess how the therapists can ensure that the therapeutic space is open and fosters an atmosphere conducive to healing? The following is based on literature and several years of clinical work with individuals classified as patients. Therapists' approaches differ; for example, a physiotherapist is "allowed" to physically touch the patient, whereas in other professions this would not be appropriate. Regardless of the profession, a positive human "touch" is a prerequisite in all encounters between human beings.

Establishing a framework is crucial. Generally, the patient will come to the therapist, at least for the first consultation. Expectations for the consultation may vary significantly between individuals, as some may not be familiar with different types of therapy. Taking time to introduce yourself and explain your offerings is time well spent. It is essential to ask the patient about their issues and concerns to be

addressed during the consultation. Still, it is also worthwhile to inquire more broadly about their general or personal background beyond health issues. If the therapist possesses knowledge of the patient's country of origin, history, culture, or general conditions, displaying genuine interest in the individual can lay the foundation for further contact and contribute to a positive atmosphere. Additionally, "mapping" the patient's interests, competencies, and experiences helps establishing balance and reduces the top-down approach. However, some patients accustomed to a more submissive relationship with health professionals may require time to understand this rationale.

Relevant literature highlights specific approaches for attending to patients. For physiotherapy, the physical touch is crucial and can make a significant impact once a safe relationship has been established. However, it may take time to achieve this. Furthermore, gender must be considered, as some patients with refugee experiences may not feel comfortable with a therapist of the opposite gender, especially during the initial phase.

Dr. Gabor Maté's talk at a digital Trauma Super Conference (2023) also outlines five levels of compassion:

1. Ordinary compassion – "… when somebody is suffering, I feel bad about that and I don't want them to suffer."
2. Compassion of understanding – "…I feel bad that you're suffering, I want to understand why you're suffering."
3. Compassion of recognition – "…I don't see myself as different from you."
4. Compassion of truth – "…I'm not trying to protect you from pain. I want you to know the truth because I believe the truth will liberate you."
5. Compassion of possibility – "… I see them for the full, beautiful human beings that they are."

Healing practices vary considerably across the globe, as illustrated in Kirmayer's article (2004). While it is impossible to be fully competent in all practices, building a relationship of trust and cooperation is vital and can be achieved to a much greater extent by all. By understanding and applying these concepts, therapists can work toward creating a therapeutic space that is open, compassionate, and conducive to healing.

Reflective activity:

Each professional should reflect on Gabor Maté's levels and be aware of their approach when attending to individuals with narratives and experiences that may significantly differ from their own. To explore and reflect on your own limitations, and always remember to see the other person as an individual with their own resources that can also help the professional to develop as a human being.

Reading:

The cultural diversity of healing: meaning, metaphor and mechanism, L. Kirmayer.
https://academic.oup.com/bmb/article/69/1/33/523337?login=false

Core competencies for physiotherapists working with refugees: a scoping review, McGowan et al.
https://www.sciencedirect.com/science/article/abs/pii/S0031940620303382?casa_token=vl19x9vSmGsAAAAA:v_Bv1AjnU6GBdYzVKzOkx_Fbpz9YusstanJzTLeS_x85o71j_9jIsr287lglvvy-zAiBdL-Img

The necessary conditions of engagement for the therapeutic relationship in physiotherapy: an interpretive description study, Miciak et al. https://pubmed.ncbi.nlm.nih.gov/29468089/

Exploring professional identity in rehabilitation professions: a scoping review, Mak et al. https://pubmed.ncbi.nlm.nih.gov/35467304/

Humor in rehabilitation professions: a scoping review, Kfrerer et al. https://pubmed.ncbi.nlm.nih.gov/35282727/

A longitudinal study of the turning points and trajectories of therapeutic relationship development in occupational and physical therapy; Horton et al. https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-06095-y

The 5 levels of compassion, from Gabor Maté. https://mountainsangha.org/the-five-levels-of-compassion/

Evidence informed practice

This section will focus on how evidence-informed practice is essential for all health and social care practices when working with people who can at times be particularly vulnerable. It highlights the importance of attending to the needs and understanding of those with refugee experience and integrating their narratives into the use of practices that are evidence-based.

Evidence-informed practice_Lecture.pptx

After watching the lecture on evidence-informed practice, think about how the ideas presented might be applied in your practice context. Your practice or organisation may or may not value practicing in an evidenced-informed manner. Schulte (2020, p125) stated that "many forms of available evidence should be used to help, heal and cure" in settings that are evidenced-based. Although she discouraged the use of anecdotal evidence and unscientific treatments, she advocated that professionals should "invest more time in the patient and in the shared decision making process". This speaks to the idea of people-centred care. The above presentation hoped to communicate that, while the use of evidence-based practices are widely considered important, it is equally important to take on board the person with refugee-experience's understanding of their situation, to work collaboratively with them so that their beliefs and values inform your evidenced-based practices.

To help you reflect on the application of evidence-informed practice to your own practice and workplace, try to answer the following question: ***How do I see evidence-informed practice being used to enhance the experience that people from refugee communities have when they enter and use my healthcare system?***

To further integrate evidence-informed practices into your own practice, review the article by Isakson et al (2015), (Isakson, B. L., Legerski, J. P., & Layne, C. M. (2015). Adapting and implementing evidence-based interventions for trauma-exposed refugee youth and families. Journal of Contemporary Psychotherapy, 45, 245-253. file:///C:/Users/saquinn/Downloads/IsaksonLegerskiLayne2015AdaptingImplementingEvidence-BasedInterventionsforTrauma-ExposedRefugeeYouthandFamiliesJCP.pdf)

Explain, in bullet format, how the points in the text can be translated into your own professional practice with this population.

Next consider how integrating these points into your own practice would influence your work, on behalf of the person, with colleagues of a different professional background.

Individual or group learning activity:

The final learning activity addressing this topic is an activity called a CAT (Critically Appraised Topic). You might find it useful to use the attached document to organise your critical appraisal Critiquing the Literature Worksheet-1.docx. If you would like to try this activity as a group, where possible establish interprofessional groups to expand your appreciation of the literature-evidence from another profession's perspective.

Source and critically appraise literature/evidence that answers the question:

What is the evidence in the literature that involvement in community-based groups enhances experiences of inclusion in the host communities for people living as refugees?

1. Find multiple pieces of evidence that answer this question by independently searching the literature.
2. Decide on the strongest pieces of evidence (3/4 or as many pieces as you can manage) that answer the above question.
3. Critically appraise the evidence.
4. Develop a 'bottom-line' conclusion that answers the question and reflects the evidence you have just appraised.

If working in a group, complete the steps as per the instructions above except, share the results of your initial search of the evidence with your group members. Then decide together on the strongest evidence and share it out among the group so that every member appraises at least some evidence. Together discuss your appraisals and develop a bottom-line.

It's better if you can work together!

Reading:

Hoffmann, T., Bennett, S. & Del Mar, C. (2013). Evidence-Based Practice Across the Health Professions. 2nd Ed. Elsevier.

Isakson, B. L., Legerski, J. P., & Layne, C. M. (2015). Adapting and implementing evidence-based interventions for trauma-exposed refugee youth and families. Journal of Contemporary Psychotherapy, 45, 245-253.

Nevo, I., & Slonim-Nevo, V. (2011). The myth of evidence-based practice: Towards evidence-informed practice. British Journal of Social Work, 41(6), 1176-1197.

Rycroft-Malone, J. O. (2008). Evidence-informed practice: from individual to context. Journal of Nursing Management, 16(4), 404-408.

Schulte, M-C. (2020). Evidence-Based Medicine - A Paradigm Ready to be Challenged? How Scientific Evidence Shapes Our Understanding and Use of Medicine. J.B. Metzler: Germany.

2.6 Promoting interaction and mutual learning between local/refugee community

Organisations and services in your locality:

The organisations and sources of support available to people with refugee experience will vary across different countries and even localities. It's important for health and social care professionals to be aware of the range of different organisations, supports and services that may be relevant and useful to people with refugee experience. Learners will explore this topic practically by investigating relevant organisations/community sources of support in their locality.

https://youtu.be/HSOidkqGZGI

Practical activity:

Identify what relevant organisations and sources of support there are in your local community.

- Briefly summarise why each may be useful to someone with refugee experience.
- Choose two organisations/sources of support and investigate what process you would need to follow to refer someone in your care to them.

Photograph ©Independent Doctors Association (IDA)

Keeping connected with local organisations and services:

To provide optimal care for people with refugee experience, health and social care professionals should establish and foster relationships with community organisations and services in their locality. This will enable them to keep up to date with the supports that may be available and how they can be accessed. It is important to be able to signpost these supports so that people with refugee experience learn who they can contact for assistance with issues or problems they may be having. The supports available to people with refugee experience will vary greatly both between countries but also even across different localities within the same country. Consequently, health and social care professionals

need to ensure that they have good understanding and awareness of the different organisations in their localities and keep up to date with changes in these and the services they provide.

Consider how you can better connect with community organizations in your locality.

- How might you make use of these links to enhance the everyday life of those with refugee experience?
- Reflecting on your practice context, is there a way that you might connect with another professional and, together with the person from a refugee community, use these supports to promote their sense of inclusion and participatory citizenship?
- What can you all learn from one another?

Module 2 Learning resources

Useful readings:

- Fook, J., & Gardner, F. (2013). Critical reflection in context: Applications in health and social care. Routledge.
- Isakson, B. L., Legerski, J. P., & Layne, C. M. (2015). Adapting and implementing evidence-based interventions for trauma-exposed refugee youth and families. Journal of Contemporary Psychotherapy, 45, 245-253.
- Nevo, I., & Slonim-Nevo, V. (2011). The myth of evidence-based practice: Towards evidence-informed practice. British journal of social work, 41(6), 1176-1197.
- Mechili et al. (2018) Compassionate care provision: an immense need during the refugee crisis: lessons learned from a European capacity-building project. Mechili et al. Journal of Compassionate Health Care (2018) 5:2.
- Mezirow, J. (2003). How critical reflection triggers transformative learning. *Adult and Continuing Education: Teaching, learning and research*, *4*, 199-213.
- Trimboli and Taylor (2016) Addressing the occupational needs of refugees and asylum seekers. Australian Occupational Therapy Journal (2016) 63, 434–437.
- Kumar et al. (2022) Meeting the health needs of displaced people fleeing Ukraine: Drawing on existing technical guidance and evidence. The Lancet Regional Health - Europe 2022;17: 100403.
- Redfern, H., & Bennett, B. (2022). An intercultural critical reflection model. *Journal of Social Work Practice*, *36*(2), 135–147. https://doi-org.elib.tcd.ie/10.1080/02650533.2022.2067139
- Rolfe, G., Jasper, M., & Freshwater, D. (2011). Critical reflection in practice: Generating knowledge for care. Palgrave Mac Millan.
- Rycroft-Malone, J. O. (2008). Evidence-informed practice: from individual to context. Journal of Nursing Management, 16(4), 404-408.

Learning supports:

- Presentation on critical reflection in practice: Critical reflection in action-1.pdf
- A pre-recorded presentation on Creating Therapeutic Space has been posted to Module 2.4 Creating therapeutic space.
- Appraising the literature worksheet: Critiquing the Literature Worksheet.docx
- Recorded lecture on evidence-informed practice: Evidence-informed practice_Lecture-1.pptx
- Case study from the Swedish Red Cross (https://www.youtube.com/watch?v=ug_WEkXeOSo)
- Live session recording on: Institutionalising Oppression - Engagement and Disengagement, Achieving Person-Centeredness

Module 2 Learning activities and assessment

There are several recommended learning activities, requiring additional reading/ reflection/ group work, in Module 2. However, just one of these is considered Module 2's assigned learning activity, the completion of which is connected to your course progress/successful completion of the course. This is found in **Module 2: Relationship with, and recognition of the needs of service-users**

Module 2 assessment requires the student to develop a **Critically Appraised Topic (CAT)**. Directions on the elements to include in your CAT are outlined in the Module 2 Assignment_Prepare a CAT document attached.

Module 2 Assignment_Prepare a CAT-2.docx

To Submit please go to Module 2 Assignment: CAT (instructure.com)

Module 3

Introduction

This module introduces theoretical and practical aspects of working collaboratively with persons with refugee experiences and professionals across disciplines, professions and sectors. It focuses on relationship building, communication skills and collaborative practice as foundations for quality health services while supporting persons with refugee experiences to access the care they need within and beyond the health systems. The module aims to challenge participants to collaborate in optimizing their performance to overcome system barriers, cultural and contextual differences in order to meet the unique needs of persons with refugee experiences, provide high quality services and achieve the best health outcomes.

A learner who has completed the module:

- has advanced knowledge of interprofessional and intersectoral collaboration and its relevance for refugee health
- can collaborate with other health and social care professionals to optimize interprofessional team performance in refugee health and social care setting
- demonstrate a critical awareness of the importance of cross-cultural communication and understanding of personal experiences of refugees

The following topics are covered in this module:

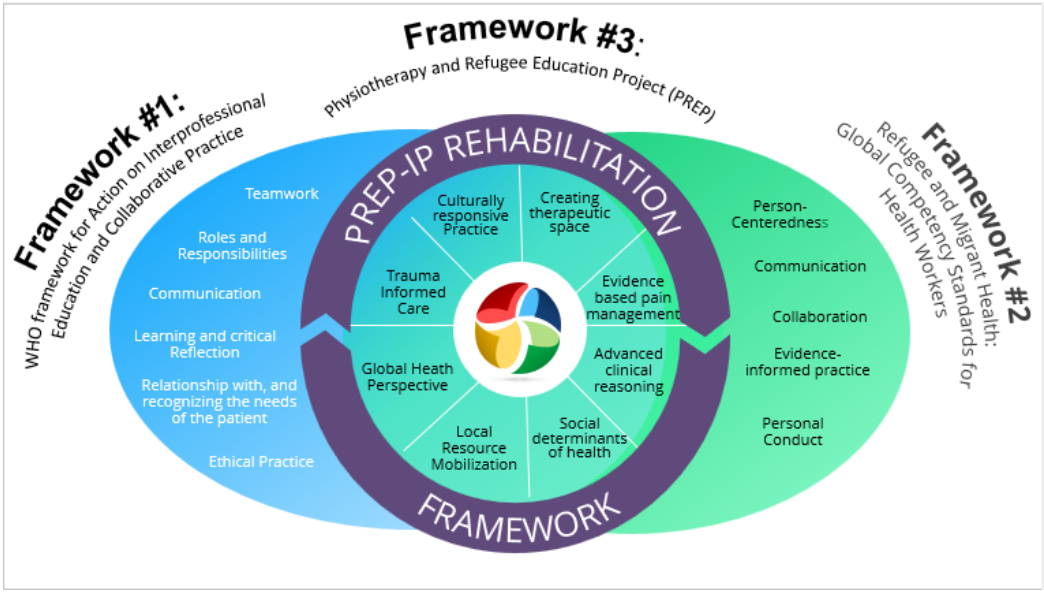
- Putting the puzzle together
- Breaking silos, crossing boundaries
- Health systems
- Navigating through health systems

During this module learners will participate in a range of learning activities including:

- engaging with curated learning resources and asynchronous discussions
- completing the module assignment (care plan and reflection)

The whole course, and particularly this module is informed by the framework developed as part of the PREP IP project. At the center of the framework are persons with refugee experiences. The framework builds on three documents:

1. WHO Framework for Action on Interprofessional Education and Collaborative Practice
2. WHO Refugee and Migrant Health: Global Competency Standards for Health Workers
3. Consensus on Key Competencies of Physiotherapists in Rehabilitation Services for Refugees and Migrants - Report (Physiotherapy and Refugee Education Project)



Background of the Above Framework (Optional information):

For further information on how we build this model, please consult the "Interprofessional Framework for Action on Online Education of Health Professionals Working with Refugees" document available at the PREP IP project website [PREP IP Reports – Persons with Refugee experience Education Project – Interprofessional (hvl.no)]

Meet persons with refugee experiences

[Photo Stories of Rohingya Refugees by David Verberckt: Survivors of a Silent Genocide]

- [Photo gallery Series I]
- [Photo gallery Series II]
- [Photo gallery Series III]

Putting the puzzle together

Seeing the whole person:

In the modern health care systems, the patient role has evolved from passive recipient of medical care to active, empowered and informed co-producer of health [4]. The Institute of Medicine (IOM) defines quality of care as: “doing the right thing, at the right time, in the right way, for the right person, and having the best possible results” [5]. In this module the participants will explore the importance of teams, assuring diversity of roles within the team, responsibilities, and tools for setting optimal goals for the client group.
Several concepts, including safety, effectiveness, patient orientation, timeliness, efficiency and equity are considered essential to quality. "Principles of human rights assert that all people are entitled to freedom - the right of every human being to participate in shaping the decisions that affect their own life and that of their society - and well-being, the ability and conditions needed to achieve one's purposes by action" [1]. Karen Hammel (2015) presented in her article that a persons' experience of diminished quality of life

might not only be explained by the physical or mental impairment, but also a consequence of environmental barriers and inequity of opportunities [1]. Previous research have found interprofessional collaboration to positively influence patient outcomes [2].

Bridging the refugee health gap: https://www.youtube.com/watch?v=3iogISgezbQ

Understanding roles in teams:

According to the WHO, Framework for action on interprofessional education and collaborative practice [3], collaborative practice in health care occurs "when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings". To do so, understanding each interprofessional team members role is vital. Roles included in the team is dependent on the context in which the team works.

Interprofessional roles and responsibilities: https://www.youtube.com/watch?v=G3add_DXZlA
Goal setting:

Goal setting is a core process that is used for multiple purposes. Goal setting is a person-centred approach, and together with an interprofessional team, aims towards getting people engaged in their own care. Furthermore, goal setting aims to reach a higher quality care and better health outcomes for the patient (6.7). Setting SMART and MEANINGful goals has been a part of rehabilitation services for the past 20-30 years and seems to be a sound way of helping patients and interprofessional team members to form goals which benefit the patient need and outcomes (6,7). A rehabilitation goal is defined as: "a desired future state to be achieved by a person with a disability as a result of rehabilitation activities. Rehabilitation goals are actively selected, intentionally created, have purpose and are shared (where possible) by the people participating in the activities and interventions designed to address the consequence of acquired disability" (7).

SMART goals:

Photo credit: https://www.physio-pedia.com/File:SMART_goals.jpg

Table credit: https://www.physio-pedia.com/SMART_Goals

Goal setting to meet individual needs: https://www.youtube.com/watch?v=i0QfCZjASX8

References:

1. Hammell, KW. (2015) Quality of life, participation and occupational rights: A capabilities' perspective. Australian journal of Occupational therapy. 62, pp. 78 - 85
2. Sorbero, ME., Farley, DO., Mattke, S., & Lovejoy, S. (2008) Outcome measures for effective teamwork in inpatient care (RAND Corporation, Trans.). Santa Monica: RAND technical report TR-462_AHRQ
3. WHO (2010) Framework for action on interprofessional education and collaborative practice. Geneva Switzerland
4. WHO (2015) Exploring patient participation in reducing health-care-related safety risks. Copenhagen, Denmark
5. Institute of Medicine (2001). Crossing the quality chasm. A new health system for the 21st century. Washington, DC, National Academy Press, 2001.
6. Lund. H. & Hjortbak, B.R. (2017) Grundlaget for rehabilitering. Munksgård, Copenhagen, Denmark.
7. Siegert, R.J. & Levack, W.M.M. (2015) Rehabilitation goal setting. Theory, practice and evidence. CRC Press, Taylor & Francis Group, New York.

Breaking silos, crossing boundaries

Introduction to teamwork

Interprofessional education “occurs when two or more professions learn with, about, and from each other to enable effective collaboration and improve health outcomes” [1-2]. In this section, participants will find information to help them develop core competencies such as interprofessional communication skills, awareness of roles and responsibilities and team function. The World Health Organization (WHO) has emphasized that interprofessional education is essential to providing optimal health services [3]. Xyrichis and Ream has defined interprofessional teamwork as "a dynamic process involving two or more health care professionals with complementary background and skills, sharing common health goals and exercising concerted physical and mental efforts in assessing, planning, or evaluating patient care" [4].

Values and ethics of interprofessional teamwork: https://www.youtube.com/watch?v=L7--0Igd0bQ

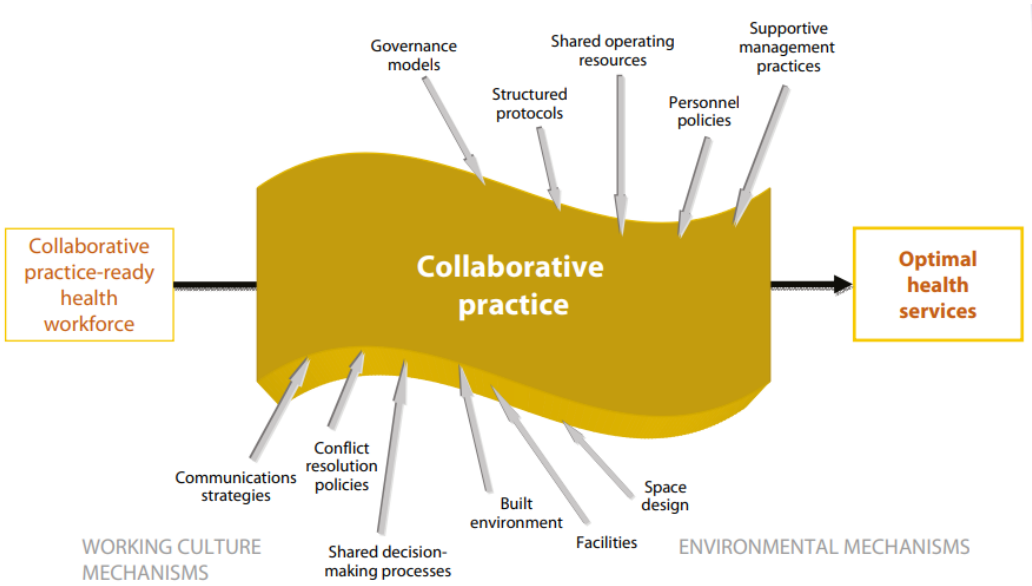


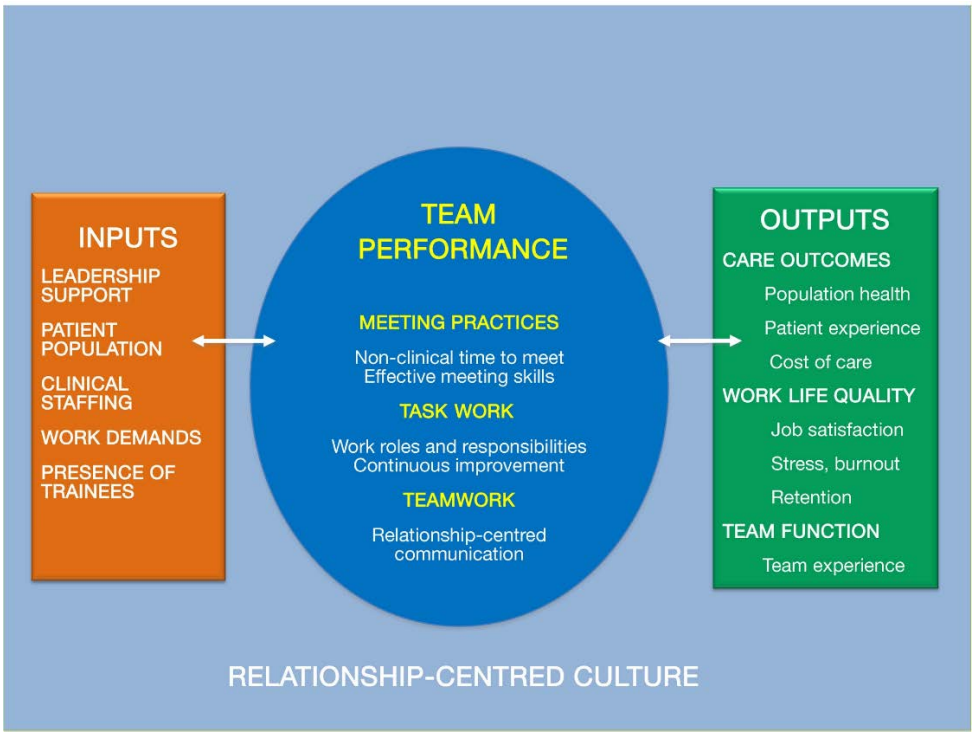
Figure 8. Examples of mechanisms that shape collaboration at the practice level

(**Figure credit:** WHO (2010), Framework for action on interprofessional education & collaborative practice)

Why interprofessional teamwork is important:

Health professionals working in various areas within health care work traditionally in interprofessional teams. However, only in the past 30 years has the value of interprofessional teams in health care been researched. Research has found that communication skills in interprofessional teams is of major importance for the safety of the patient and quality of care [10]. Quality of care is defined by the Institute of Medicine (1990) and sited by the WHO in their report on Delivering quality health services. A

global imperative for universal health coverage from 2018 to be the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" Furthermore, WHO (2018) states that "high-quality health services involve the right care, at the right time, responding to the service users' needs and preferences, while minimizing harm and resource waste. Quality health care increases the likelihood of desired health outcomes and is consistent with seven measurable characteristics: effectiveness, safety, people-centeredness, timeliness, equity, integration of care and efficiency". To achieve quality of care an input-process-output model should be conceptualized [8].



(Model credit: Warde, C.M., Giannitrapani, K.F. and Pearson, M.L. (2020), Teaching primary care teamwork: a conceptual model of primary care team performance. Clin Teach, 17: 249-254. https://doi.org/10.1111/tct.13037)

https://www.youtube.com/watch?v=xjXxx3gBmO8

Teams and teamwork: https://www.youtube.com/watch?v=IRIkJKppR_8

Communication and relational coordination:

Core values of interprofessional teamwork include optimal communication, shared goals, shared knowledge and mutual respect between health professionals in the team and the service users involved [5]. Communication has been highlighted in previous reviews [9], and was identified as a key feature of teamwork within the three categories of the input-process-output model [9]. Aspects, such as communication skills, use of communication tools inform and guide interprofessional teamwork. Knowing and understanding what promote good communication in teams is important. However, understanding and recognizing aspects hindering good communication in interprofessional teams is also important. These hinders can be insufficient reporting and poorly prepared team meetings [9]. Team

communication occurs both formally in i.e. team meetings and informally i.e. occurring spontaneously in the office.

Communication skills in interprofessional teams: https://www.youtube.com/watch?v=W0ZbfsBOBUA

Interprofessional communication: https://www.youtube.com/watch?v=p75Qkn-953A

Share your experience of working with refugees by posting in Module 3: Working with persons with refugee experience. How do you address health needs of persons with refugee experiences? Do you work in an interprofessional team? How do you put the puzzle together? How do you break down silos and cross the professional and sectoral boundaries?

References:

1. IPEC (2011) Core Competencies for Interprofessional Collaborative Practice: pdf
2. IPEC (2016) Core Competencies for Interprofessional Collaborative Practice - update: pdf
3. World Health Organization, Framework for action on interprofessional education & collaborative practice. 2010
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5. Gittell, JH., Godfrey, M & Thistlehwaite, J. (2013) Interprofessional collaborative practice and relational coordination: improving health care through relationships. Journal of interprofessional care, 27(3), 210 - 213.
6. WHO (2018) Delivering quality health services. A global imperative for universal health coverage. Geneve, Switzerland
7. Institute of Medicine (US) (1990) Committee to Design a Strategy for Quality Review and Assurance in Medicare. Medicare: A Strategy for Quality Assurance: Volume 1. Lohr KN, editor. Washington (DC): National Academies Press (US); 1990. PMID: 25144047.
8. Cohen, SG. & Bailey, DE. (1997) What makes teams work: group effectiveness research from the shop floor to the executive suite. Journal of Management, 23(2), 239 - 290
9. Paxino, J. et al (2020) Communication in interprofessional rehabilitation teams: a scoping review. Disability and rehabilitation
10. Husebø, SE. & Ballangrud, R. (2021) Teamwork in health care services. From a quality and patient safety perspective (Norwegian only). Universitetsforlaget, Oslo.

Health systems and structures

Photo Credit: https://dol.ior.kit.edu

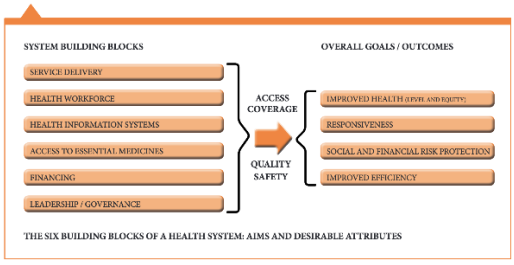
Background

Why is studying health systems important for this course? Quick Answer: The structure of a health system can be a *facilitator* or a *barrier* to accessing care, and understanding the structure is particularly relevant to people with refugee experience as they attempt to navigate a new and complex health system and where they likely have a series of disadvantaged (for instance, different language, culture, locus of power, etc...)

Although several operational definitions of a 'health system' have been proposed, they all generally describe the organization and interaction between people, places, institutions, and resources in delivering health services/products. The penultimate objective of a health system is meeting the needs of defined populations. Still, there exist in tandem other purposes that mediate this ultimate goal, including (but not limited to) maintaining financial sustainability, improving efficiencies, and maintaining high quality of care to name just a few.

In 2010, the World Health Organization (WHO) published a seminal report called "Monitoring The Building Blocks of Health Systems" (see reference below), where they define the six system building blocks, and four overall goals. See the figure below, taken directly from the publicly accessible WHO report (WHO, 2010)

Figure 1. The WHO Health Systems Framework



Defining the six building blocks

Health Service Delivery: Health service delivery is the application or allocation of the services (whether initiated by health professionals or by volunteers) or products offered in a health system. Characteristics of quality service delivery include; (1) *Comprehensiveness* of the services/product offered along the continuum of care from palliative care and curative interventions at one end through to rehabilitative, home care, and preventive service at the other, (2) Efficient *accessibility* of service and products for users/patient, (3) Wide *coverage* (financing) of services/products for all within the target population, (4) Effective *continuity* of services/products, (5) High *quality* of services/products, (6) Person-centeredness so that patient needs drive services/products, (7) Coordination of services/products across the continuum, and (8) full accountability and efficiency so that services/ products are well managed.

Health Human Resources (Workforce): The number, types and distribution of health professionals arranged to meet the health needs of the target population.

Health Information Systems: Availability of valid and reliable data that can be used to drive decision-making, critical for policy and clinical decision-making, across the health system.

Access to Essential Medicines: Equitable access to essential medical products, vaccines and technologies.

Health System Financing: Existence of stable and sufficient funding derived though public, private or mixed revenues that ensure access to health services/product.

Leadership and Governance: Effective and efficient management of the relationships between a health system's different (and often competing) elements (Governance), and fair and ethical leadership infrastructure to coordinate assets and resources towards positive health system outcomes.

Health System Goals

A health system's goals can differ depending on the nature, type, or even location of the part of the system. Nevertheless, the goals are generally to produce positive health outcomes for patients (or eligible stakeholders) and their families. As described in Figure 1 above, the evaluation of a system rests primarily on its ability to improve health, be responsive to the ever-changing needs of a population, and establish social and financial risk protection (meaning that ability to pay for care is not a barrier) and improved efficiency (meaning generating health outcomes with fewer resource inputs).

The WHO document referenced below provides an excellent review of the monitoring and evaluation of health systems, including the many indicators and sub-indicators. We encourage all leaders to engage with that key learning resource.

Health Systems Utilization and Persons with Refugee Experience

Given the often-tortious journey for Persons with refugee experience, they often present with important health and rehabilitation needs. As reported by Mangrio et al. (2018), although refugees have healthcare needs, they seek care at a different rate than the national population in Sweden. They report that the reasons include the high cost of care (i.e., new arrivals into a country are only sometimes fully insured under a national health plan), long wait times, and language barriers. Lebano et al. (2020) then report that even under the best of intentions, health systems often need to be arranged to meet the

specific needs of refugees, stating language and communication barriers as the rationale. Overall, there exist barriers that limit access to health systems, not only for refugees but for most populations that may need to fit precisely into the framework of a system. For refugees, this limited access likely results in the progression of health and rehabilitative health conditions.

With the acknowledgment that a challenge exists, the next question might be how to reduce or even eliminate the barriers.

Key Learning Resource for this Topic

1. WHO Monitoring The Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies (2010) **https://apps.who.int/iris/bitstream/handle/10665/258734/9789241564052-eng.pdf**
2. Podcast: Global Health Matters: Episode 17: The Health Journey of Refugees and Migrants *is* Global Health https://www.youtube.com/watch?v=LQxFiAFFcGQ&t=204s (36:59 mins)

Other Learning Resources

1. Mangrio, E., Carlson, E., & Zdravkovic, S. (2018). Understanding experiences of the Swedish health care system from the perspective of newly arrived refugees. *BMC research notes*, *11*(1), 1-6.
2. Sharara, E., Akik, C., Martini, M., & DeJong, J. (2021). Health system considerations related to voluntary and forced displacement in the Eastern Mediterranean Region: a critical analysis of the available literature. *Eastern Mediterranean Health Journal*, *27*(12), 1214-1228.
3. Lebano, A., Hamed, S., Bradby, H., Gil-Salmerón, A., Durá-Ferrandis, E., Garcés-Ferrer, J., ... & Linos, A. (2020). Migrants' and refugees' health status and healthcare in Europe: a scoping literature review. *BMC public health*, *20*, 1-22.
4. Health Systems Review: The University of Maryland https://www.youtube.com/watch?v=ECkeJQd2IdY (7:19 mins)
5. Khan Academy: Health Systems https://www.youtube.com/watch?v=LMHxxvbzFqc (8:01 mins)

Navigating through health systems

Photo Credit: https://patientengagementhit.com

Background

Evans et al. (2023) reported, "*Government-assisted refugees may benefit from longer-term resettlement support related to health care navigation, even in a health care system that publicly funds all physician care and hospital admissions.*" In the context of their publication, "Health care navigation" referred to a process where individuals (or groups) could advocate for refugees seeking prenatal care. Being an effective navigator presupposes that the 'Navigator' is knowledgeable about the health systems and the existing complex configurations (or the building blocks as we discussed in 3.3 of this Module). Having an effective Navigator can positively impact access to needed care. At the same time, this effectiveness of a Navigator is also (and 'often') necessary among the non-Refugee populations with a health system, given the particular vulnerability among people with refugee experience who often arrive with much less information (also called 'information asymmetry) and a much different level of power.

Yun et al. (2016) found similar findings at the community level among Bhutanese Refugees seeking care in the United States. Concerning navigating health systems, they report that "*These tasks are rarely trivial for U.S. citizens [1,2,3,4,5]. They may be all but insurmountable for immigrants with limited literacy. English proficiency, or prior experience with comparable health systems*."

The overall problem is that there likely exists a series of barriers for people with refugee experience to access care. These barriers can include (but not limited to) a lack of information and knowledge of health systems, distrust in systems, perceived inaccessibility to care, and even unclear health insurance eligibility.

A partial solution, especially in the short term, could be applying some form of navigation model.

Defining 'Navigation' with a Health System

There are different models of 'Health system navigation,' ranging from informal individuals who have an interest in helping through to much more sophisticated and formal structures that are integral to a health system. According to Rightway Health, a navigator role can accomplish or focus on the following (bullet points below are taken directly from their website)

- Assist patients in finding the right treatment and going through with all of it (i.e., screening, diagnosis, treatment, and follow-up check-up).
- Help patients understand their illnesses or diagnosis so they can make sound decisions regarding their health.
- Explain to them their healthcare packages or plans.
- Help patients come to terms with their illness and offer emotional support throughout their whole treatment.
- Help patients find, communicate, and voice out their concerns with their healthcare providers.

Goals of Health System Navigation

The ultimate goal of health system navigation is lowering barriers to access for an individual can access the care they need. As mentioned above, most individuals would benefit from a health system navigator.

Still, given the often-precarious situation in which refugees live in a new environment, they may be particularly in greater need.

The Primary Care Network (PHN) Care Navigation (https://thephn.com.au) description provides an excellent overview of navigation goals. Please review the following short 6:25 min video https://www.youtube.com/watch?v=IS3fMzxDO2c

Importance of Health System Navigation for Persons with Refugee Experience

The Sheriff et al., (2022) article (see below) provides a series of excellent and well-informed series of argument for the importance of the navigation role, notably; among refugees. Further, Vu et al. (2022) suggested the following " *While understudied, the use of patient navigators holds potential for increasing refugee women's SRH care access and utilization. Patient navigation can both effectively address language-related challenges for refugee women and help them navigate the healthcare system for SRH. Future research should explore organizational and external factors that can facilitate or hinder the implementation of patient navigators for refugee women's SRH [sexual and reproductive health] care.*"

However, to reverse/pivot the argument from a health policy perspective, what would be the predictable or expected outcomes if effective navigation processes or tools are not introduced to facilitate access for refugees? Please reflect on this scenario, and join the discussion by posting your response to the question in Module 3: Importance of Health System Navigation for Persons with Refugee Experience

Key Learning Resources for this Topic

1. Evans, A., Ray, J. G., Austin, P. C., Lu, H., Gandhi, S., & Guttmann, A. (2023). Receipt of adequate prenatal care for privately sponsored versus government-assisted refugees in Ontario, Canada: a population-based cohort study. *CMAJ*, *195*(13), E469-E478.

2. Yun, K., Paul, P., Subedi, P., Kuikel, L., Nguyen, G. T., & Barg, F. K. (2016). Help-seeking behavior and health care navigation by Bhutanese refugees. *Journal of community health*, *41*, 526-534.

Other Learning Resources

1. Salinas, M., Matarrita-Cascante, D., Salinas, J. L., & Burdine, J. N. (2021). Navigating healthcare systems before and after resettlement: Exploring experiences and recommendations for improvement from the perspectives of a Bhutanese refugee community. *Journal of Migration and Health*, *4*, 100049.

2. Vu, M., Besera, G., Ta, D., Escoffery, C., Kandula, N. R., Srivanjarean, Y., ... & Hall, K. S. (2022). System-level factors influencing refugee women's access and utilization of sexual and reproductive health services: A qualitative study of providers' perspectives. *Frontiers in Global Women's Health*, *3*.

3. Sherif, B., Awaisu, A., & Kheir, N. (2022). Refugee healthcare needs and barriers to accessing healthcare services in New Zealand: a qualitative phenomenological approach. *BMC Health Services Research*, *22*(1), 1310.

4. Dimitropoulos, G., Morgan-Maver, E., Allemang, B., Schraeder, K., Scott, S. D., Pinzon, J., ... & Samuel, S. (2019). Health care stakeholder perspectives regarding the role of a patient navigator during transition to adult care. *BMC Health Services Research*, *19*, 1-10.

Module 3 Learning resources

Readings

Putting the puzzle together and Breaking silos, crossing boundaries

Gittell, JH., Godfrey, M & Thistlehwaite, J. (2013) Interprofessional collaborative practice and relational coordination: improving health care through relationships. *Journal of interprofessional care, 27*(3), 210 - 213.

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Ho, S., Javadi, D., Causevic, S., Langlois, E. V., Friberg, P., & Tomson, G. (2019). Intersectoral and integrated approaches in achieving the right to health for refugees on resettlement: a scoping review. *BMJ open*, *9*(7), e029407.

Institute of Medicine (US) (1990) Committee to Design a Strategy for Quality Review and Assurance in Medicare. Medicare: A Strategy for Quality Assurance: Volume 1. Lohr KN, editor. Washington (DC): National Academies Press (US); 1990. PMID: 25144047.

Institute of Medicine (2001). Crossing the quality chasm. A new health system for the 21st century. Washington, DC, National Academy Press.

IPEC. (2011). Core Competencies for Interprofessional Collaborative Practice.

IPEC. (2016). Core Competencies for Interprofessional Collaborative Practice - Update.

Paxino, J. et al. (2020). Communication in interprofessional rehabilitation teams: a scoping review. *Disability and rehabilitation, 44*(13), 3253-3269, DOI: 10.1080/09638288.2020.1836271

Phillips, C. B., Smith, M. M., Kay, M., & Casey, S. (2011). The Refugee Health Network of Australia: towards national collaboration on health care for refugees. *Medical Journal of Australia*, *195*(4), 185-186.

Siegert, R.J. & Levack, W.M.M. (2015). *Rehabilitation goal setting. Theory, practice and evidence*. CRC Press, Taylor & Francis Group, New York.

Sorbero, ME., Farley, DO., Mattke, S., & Lovejoy, S. (2008) Outcome measures for effective teamwork in inpatient care (RAND Corporatin, Trans.). Santa Monica: RAND technical report TR-462_AHRQ

Veronis, L. (2019). Building intersectoral partnerships as place-based strategy for immigrant and refugee (re) settlement: The Ottawa Local Immigration Partnership. *The Canadian Geographer/Le Géographe canadien*, *63*(3), 391-404.

World Health Organization. (2018). Delivering quality health services. A global imperative for universal health coverage. Geneve, Switzerland

World Health Organization. (2015). Exploring patient participation in reducing health-care-related safety risks. Copenhagen, Denmark

World Health Organization. (2010). Framework for action on interprofessional education & collaborative practice.

World Health Organization. (2023). *Refugee and migrant health toolkit: one-stop resource for countries to advance the health and migration agenda* (No. WHO/DDG/PHM/2023.1). World Health Organization. Available at Refugee and Migrant Health Toolkit (who.int) and WHO-DDG-PHM-2023.1-eng.pdf (see Module 5 and 6)

Xyrichis, A, & Ream, E. (2008) Teamwork: a concept analysis. *Journal of Advanced Nursing, 62*.

Navigating Health Systems and Structures and Navigating through Health Systems

Dimitropoulos, G., Morgan-Maver, E., Allemang, B., Schraeder, K., Scott, S. D., Pinzon, J., ... & Samuel, S. (2019). Health care stakeholder perspectives regarding the role of a patient navigator during transition to adult care. *BMC Health Services Research*, *19*, 1-10.

Evans, A., Ray, J. G., Austin, P. C., Lu, H., Gandhi, S., & Guttmann, A. (2023). Receipt of adequate prenatal care for privately sponsored versus government-assisted refugees in Ontario, Canada: a population-based cohort study. *CMAJ*, *195*(13), E469-E478.

Lebano, A., Hamed, S., Bradby, H., Gil-Salmerón, A., Durá-Ferrandis, E., Garcés-Ferrer, J., ... & Linos, A. (2020). Migrants' and refugees' health status and healthcare in Europe: a scoping literature review. *BMC public health*, *20*, 1-22.

Mangrio, E., Carlson, E., & Zdravkovic, S. (2018). Understanding experiences of the Swedish health care system from the perspective of newly arrived refugees. *BMC research notes*, *11*(1), 1-6.

Salinas, M., Matarrita-Cascante, D., Salinas, J. L., & Burdine, J. N. (2021). Navigating healthcare systems before and after resettlement: Exploring experiences and recommendations for improvement from the perspectives of a Bhutanese refugee community. *Journal of Migration and Health*, *4*, 100049.

Sharara, E., Akik, C., Martini, M., & DeJong, J. (2021). Health system considerations related to voluntary and forced displacement in the Eastern Mediterranean Region: a critical analysis of the available literature. *Eastern Mediterranean Health Journal*, *27*(12), 1214-1228.

Sherif, B., Awaisu, A., & Kheir, N. (2022). Refugee healthcare needs and barriers to accessing healthcare services in New Zealand: a qualitative phenomenological approach. *BMC Health Services Research*, *22*(1), 1310.

Vu, M., Besera, G., Ta, D., Escoffery, C., Kandula, N. R., Srivanjarean, Y., ... & Hall, K. S. (2022). System-level factors influencing refugee women's access and utilization of sexual and reproductive health services: A qualitative study of providers' perspectives. *Frontiers in Global Women's Health*, *3*.

World Health Organization. (2010). Monitoring The Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies.

Yun, K., Paul, P., Subedi, P., Kuikel, L., Nguyen, G. T., & Barg, F. K. (2016). Help-seeking behavior and health care navigation by Bhutanese refugees. *Journal of community health*, *41*, 526-534.

Slides/Video

Module 3 slides Oct 31 2023.pdf

Module 3 Learning activities and assessment

Discussion

- Module 3: Working interprofessionally with persons with refugee experience

Module Assignment

- Facilitators and barriers to interprofessional practice in settings with persons with refugee experience.

Module 4: Diversity in Society & in Health Care (HAWK)

Introduction to Module 4

Respecting diversity in society and in healthcare: Implications for interprofessional collaboration in refugee health

This module will look at culturally responsive interprofessional health services for persons with refugee experience as a response to increasing societal diversity leading to demands for equal health opportunities. Relevant key concepts such as culture, diversity, intersectionality, health equity and structural racism will be introduced. The module will allow students to engage with essential aspects of culturally responsive practice at the micro, mezzo and macro levels of health care provision as a basis for interprofessional collaboration in refugee health. In this context, particular emphasis lies on the concept of cultural humility. Following this, strategies for successful cross-cultural communication are discussed. Diversity in society and healthcare calls for a commitment to promoting equity and reducing health disparities across diverse communities. This calls for engagement with interprofessional ethical practice and issues of personal conduct in refugee health. Advanced clinical reasoning is introduced as a way of dealing with the unique healthcare needs and challenges persons with refugee experience are likely to encounter. Furthermore, the question is addressed how health professionals can contribute to advocacy and empowerment in the field of refugee health.

A student who has completed the module:

- has knowledge and understanding of the related concepts of culture, diversity and health equity and their relevance for developing culturally responsive practice when working with people with refugee experience.
- has appreciation of the effect of interprofessional collaboration on improving cross-cultural communication and can employ essential cross-cultural communication strategies in their own clinical practice.
- can engage with case stories and narratives of persons with refugee experience to critically appraise profession-specific and interprofessional approaches to enhancing refugee health.

- has knowledge of and can relate to interprofessional ethical practice based on core values and principles relevant in interprofessional refugee health.
- is aware of the influence of various health determinants on the healthcare situation of persons with refugee experience and can acknowledge them during advanced clinical reasoning processes.
- can critically appraise the need for advocacy and empowerment in refugee health and has the ability to integrate this into his or her professional role.

Topics

1. Culturally responsive practice
2. Cross-cultural communication
3. Ethical practice and personal conduct
4. Advanced clinical reasoning
5. Advocacy and empowerment

During this module learners will participate in different learning activities including:

- engaging with curated learning resources (watching videos, readings, sourcing and critically appraising literature)
- discussing narratives, case studies and clinical examples
- engaging in critical self-reflection
- aligning profession-specific approaches with perspectives from interprofessional team collaboration
- completing individual and group work (discussions, reflection, peer review/feedback)

Meet persons with refugee experiences

80 years apart, these two refugees have more in common than you'd think | UNICEF (youtube.com)

Culturally Responsive Practice in Refugee Health

Understanding Relevant Concepts: Culture, Diversity and Health Equity

International literature indicates that healthcare practitioners sometimes struggle to understand the meaning of culturally responsive practice "due to the perceived complexity and indeterminate nature of the concept of culture"(Minnican & O'Toole 2020). Culture is a word that is familiar to everyone, but its precise meaning can be elusive. Since the term "culture" is understood very differently in academia depending on the epistemological interests of the authors using it, this module starts with an introduction of the constructivist understanding of culture (that originated in the humanities) and the related concepts of diversity and health equity in relation to interprofessional refugee health.

People as products and creators of culture – the constructivist understanding of culture

The outdated positivist (or ethnicised) understanding of culture and cultural groups typically equates origin with culture and thus defines people in terms of their (presumed) ethnic, national or religious origin and affiliation. In this view, cultures are supposedly given entities that can be observed and described, that have clear boundaries to other cultures and that change only slowly. The basic assumption that members of a group share certain characteristics leads to a simplistic description of expected ways how people will think and behave, which hinders the perception of real-life heterogeneity and ambiguities and encourages stereotyping. It also disregards the dynamic processes of human action.

In constructivist theory, cultures are no longer understood as entities to be found in reality, but rather, the "reality" of culture that we believe we can see and describe in the real world is always also a consequence of how we understand culture. This reflects the epistemological basis of cognitive theory: we socially and culturally, i.e. collectively, generate our reality. Such an open, process-, meaning- and practice-oriented concept of culture is interested in the learned patterns of how individuals and groups perceive and interpret the world and how they adapt to it. Worldwide social, political and economic upheavals and, not least, global migration processes have fundamentally challenged the idea that the world is a mosaic of separate and unchangeable cultures. Current academic debates consequently conceptualise culture within complex, increasingly differentiating and thus highly heterogeneous social contexts. In healthcare, the way people understand health and illness and the health/illness behaviour they exhibit accordingly is not only seen as influenced by their language, cultural beliefs and practices, but also by a range of social and economic factors, by the specific organisation of a healthcare system and by a person's health literacy, i.e. the ability to understand health and use health services.

Culture relates to group identity and a mostly unconscious expression of similarities. It is a system of beliefs, values, rules and customs shared by a group and used to interpret experiences and direct patterns of behaviour. Culture can be described at different levels, including the organizational and group level, e.g. in the context of interprofessional teamwork. In the constructivist view culture is something learned, not innate, and though it may seem persistent, culture is always changing. Since we are all members of different groups, we are all influenced in a unique way by a diversity of cultural backgrounds. Cultures and the people who belong to them are heterogeneous; belonging to a culture does not define the whole person. We all learn culture from many different sources, e.g. parents and other family members, friends and peers, neighbourhood and community members, educational institutions, social institutions, religious affiliation, the media, shared experiences of events, historical traditions and stories.

Awareness of one's own cultural influences (what are my own cultural roots and values?) and the ability to question one's own attitudes (where do they come from? how do they influence my behaviour?) are important prerequisites for the ability to meet the health care needs of people with refugee experience, but also for the ability to function in an interprofessional team.

Self-Reflection Exercise: What are my own cultural influences?

The following two worksheets for self-reflection were created by Eirini Adamopoulou, PhD, National and Kapodistrian University of Athens, for the project "InterAct Interdisciplinary cooperation in Psychosocial interventions: A Case Study on Refugees" (co-funded by the Erasmus+ Programme of the European

Union) and used with permission. For more information on the project and the resources created access: http://interact-erasmus.eu/

- InterAct_Work Sheet 1_My Cultural Identity Pie Chart
- InterAct Work Sheet 2. "Where are you local?"

From Culture to Diversity: Health Equity in a Diverse Society

In the positivist understanding of science long dominant in the health sciences, little attention was paid to the question of the emergence of categories of difference. More recently, the concept of diversity which was brought forward by the interdisciplinary research field of Diversity Studies, seeks to explain the effects of social categories of difference on people's individual life situations and the associated experiences and perspectives. On the one hand, this development is rooted in the effects of transnational migration and globalisation processes, and on the other hand, it is the result of human rights concerns of social movements such as the black anti-racism and civil rights movement, the women's and LGBTIQ* movement or the disability rights movement, which have ensured recognition of rights and equal opportunities for different groups in a pluralistic society.

Research from a diversity perspective postulates that differences are not inherently given but result from social practices of distinction. As a consequence, it aims to explore how certain social categories become categories of difference within existing social power relations influenced e.g. by racism, ethnocentrism, (hetero)sexism, classism and ableism, upon which power hierarchies are built. In this context, the concept of intersectionality (Crenshaw 1989) draws attention to the complex interactions between various inequality-generating categories of difference that can influence each other and mutually reinforce or alleviate each other. Typically, categories of difference are created through binary opposition, i.e. the understanding of one's own social identity and position in society is created through demarcation from that of the (seemingly) other. Such processes of "othering" are based on implicit bias and the associated stereotypes and prejudices. Since social power relations are firmly rooted in socialisation processes, they are often taken for granted by members of the socially dominant groups and thus become invisible. For example, "the description and categorisation of people, as it occurs in cross-cultural nursing research and practice, most often takes place from within a White dominant perspective, presented to White audiences, and focuses on description of a non-White or a non-Western group" (Campesino 2008).

In this context, the human right to health plays a central role, because it expresses the normative conviction that people must not be disadvantaged on the basis of characteristics or attributions such as social origin, ethno-culturally coded or racialised affiliation, gender or sexual orientation, age or physical or mental condition. From a social justice perspective, diversity in society and healthcare calls for a commitment to promoting equity and reducing health disparities across diverse communities to improve health outcomes for all individuals, particularly those from marginalized communities. This perspective emphasizes the importance of recognizing and addressing the systemic barriers and social determinants of health that impact individuals and communities from diverse backgrounds, such as poverty, racism, and discrimination.

"In the context of discourse in society as a whole and also specifically in psychosocial work on flight, trauma and violence, culturalising and racialising assumptions about the situation of refugees are the

normal state of affairs. Racism is a solution to many social challenges that has been tried and tested for centuries, since colonialism. It is a transgenerational body of knowledge that is readily available and can be accessed. It is therefore not surprising that racist and culturalising explanatory patterns are used to explain and categorise complex and overwhelming situations. Often, the solution to these problems lies outside the sphere of influence of individual professions and structures, even though they are active in the context of flight, trauma and violence, which can reinforce the dynamic of arguing in a racist and culturalising way in order to cover up the powerlessness in the face of structural hurdles and to shift the responsibility to the person." (BAfF 2022)

From a diversity perspective, the situation of persons with refugee experience can be understood as a complex intersection of various factors such as cultural, ethnic, religious, and linguistic backgrounds, as well as socioeconomic status, political context, and past experiences of displacement and trauma. Health professionals should e.g. be aware of the importance of residence status on a person's life situation – as it influences access to health services, to the education system, to the labour market, possibilities to participate in cultural activities, the right or denial to choose one's own residence, as well as a person's overall future prospects and associated potential psychosocial burdens.

References:

BAfF e.V. / Leonie Teigler (ed.). *Mächtige Narrative – was wir uns nicht erzählen: Über den Zusammenhang von Gewalt, Stress und Trauma im Kontext Flucht*. [*Powerful narratives - what we don't tell ourselves: On the connection between violence, stress and trauma in the context of flight*. In German language]. BAfF e. V. (2022). Available at: https://www.baff-zentren.org/produkt/maechtige-narrative/

Campesino, Maureen. Beyond Transculturalism: Critiques of Cultural Education in Nursing. *Journal of Nursing Education* 47(7) 2008:298–304. DOI: 10.3928/01484834-20080701-02

Crenshaw, Kimberlé. Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics," *University of Chicago Legal Forum*: Vol. 1989, Article 8. Available at: https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Reading Exercise: Dismantling Structural Racism in Interprofessional Collaborative Practice

Read the following text:

Cahn, Peter S. How interprofessional collaborative practice can help dismantle systemic racism, *Journal of Interprofessional Care*, 34:4, 2020, 431-434, DOI: 10.1080/13561820.2020.1790224

Think about your answers to the following questions:

1. The author critizes the "artificial separation between interprofessional collaborative practice and anti-racism"? Which arguments does he bring forward to substantiate this view? Do you agree with this perspective? Why (not)?
2. How does the text characterize "structural competency"?
3. Considering that the text is concerned with interprofessional collaborative healthcare practice and racism in the United States: do you see parallels to the interprofessional collaborative healthcare practice and the situation of persons with refugee experience in your own country?

What can you learn from this text regarding culturally responsive interprofessional practice in refugee health?

Practice Experience: The Role of Occupational Therapists in Supporting Persons with Refugee Experience in Germany

Please read the interview with Angelika Roschka, M.Sc., who is an occupational therapist, lecturer in the Occupational Therapy programme at Ernst-Abbe-Hochschule Jena, University of Applied Sciences, and a trainer and coach for transculture, anti bias and democracy. Angelika has years of experience working with refugees in a small town in Germany. Prior to this, she worked as a community occupational therapist in Kathmandu, Nepal, and then in Cairo, Egypt, conducting and supervising the training of teachers in therapeutic assessment and intervention of children with special needs.

Questions:

1. How does Angelika Roschka describe the unique professional perspective, role and approaches of an occupational therapist supporting persons with refugee experience?
2. Which examples does she provide that illustrate the connection between the concepts of culture, diversity and health equity described in the introduction?
3. If you are an occupational therapist: would you describe the occupational therapy perspective on working with persons with refugee experience in your own country in a similar way? If you are from another health profession: what unique professional perspectives, roles and approaches does your own profession bring to interprofessional teams?
4. What kind of interprofessional collaborative practice does Angelika Roschka mention? In addition to that, which other types of culturally-responsive interprofessional collaboration in refugee health can you describe?

Cultural influences on understanding illness and pain

Pain is a common symptom of many medical conditions, but for healthcare professionals pain assessment, pain management and adjustment of pain medication can be challenging. Living in a diverse society requires healthcare providers to respect and take into account the particular cultural backgrounds from which their patients come. Pain is perceived by the patient and can only be reported by the patient. It is subjective and can be difficult to describe, as it not only requires a degree of self-awareness, but is strongly influenced by the patient's unique socialisation and cultural background. This leads to the expectation that:

1. health professionals respect the beliefs, experiences and values of patients, their families and communities,
2. that they are able to communicate effectively with them, but also with other professionals and within interprofessional teams,
3. that they are aware of the potentially positive and negative influence of provider and system factors on effective pain assessment and pain management and
4. that they can advocate for patients on individual, system and policy levels.

Self-reflection exercise:

1. How do cultural influences and socialisation influence your understanding of illness and health and your approach to illness and prevention? To what extent do you as an individual have a unique cultural perspective?
2. What is pain, how is pain relieved? How do cultural influences and socialisation affect your experience of pain (feeling pain, describing pain, dealing with pain)?
3. How do cultural influences and socialisation influence the way you as a health professional deal with pain assessment and pain management?
4. How is pain assessed, quantified, and communicated? How do cultural, institutional, societal and regulatory influences affect pain assessment and pain management?

Viewing, reading and discussion exercise:

Now watch the two presentations by Victoria Zander, PT, PhD about the impact of migration on pain.

Presentation 1: Migration and Pain (7.58")

Take notes of your answers to the following questions:

1. How does Victoria Zander describe the healthcare situation of persons with refugee experience in Sweden? What are typical health concerns and determinants of health for people with refugee experience?
2. How does she explain the influence of (forced) migration on the perception of chronic pain?
3. What could be your own profession‘s role in this context?

Presentation 2: Migration and health, (6.57")

Take notes of your answers to the following questions:

1. How does Victoria Zander describe the connection between culture, health/illness beliefs, perception of pain and help-seeking behaviour?
2. How does she characterize the challenge provided to health professionals treating migrant or refugee patients with chronic pain? Which solutions does she suggest?
3. What are your own experiences in professional practice with persons with refugee experience?

Read the guest editorial by Cass McGregor & Jackie Walume “We need to develop our approach to socially constructed concepts including socioeconomic factors, power, ethnicity and racism in pain care and research" In: *Pain and Rehabilitation – the Journal of Physiotherapy Pain Association* 51, 2021, 1-4. Available at: https://www.ingentaconnect.com/content/ppa/pr/2021/00002021/00000051/art00001

Take notes of your answers to the following questions:

1. How do Cass McGregor & Jackie Walume describe the current understanding of the relationship between socially constructed concepts (such as ethnicity) and the experience of (chronic) pain in health research?

2. How do they characterize the complexity and differences between socioeconomic factors and ethnicity?
3. Does this shift your focus on the challenges associated with migrant or refugee patients with chronic pain and your understanding of possible solutions?

Now have an exchange about your answers with 2-3 learners from other professions.

Write a joint statement (150-200 words) that describes the benefits of interprofessional collaboration in managing chronic pain in refugee health in a culturally-responsive way.

Recommended further reading:

Gordon, Debra B.; Watt-Watson, Judy; Hogans, Beth B. Interprofessional pain education – with, from, and about competent, collaborative practice teams to transform pain care. *PAIN Reports* 3(3):p e663, May/June 2018. | DOI: 10.1097/PR9.0000000000000663

Narayan, Mary C. Culture's Effects on Pain Assessment and Management: Cultural patterns influence nurses' and their patients' responses to pain. In: AJN 110(4), 2010, 38-47

Sharma, Saurab, Pathak, Anupa, Jensen, Mark P. Words that describe chronic musculoskeletal pain: implications for assessing pain quality across cultures. *J Pain Res*. 2016;9: 1057-1066. https://doi.org/10.2147/JPR.S119212 (= compares the words that individuals with chronic pain from Nepal use to describe their pain with those used by patients from the USA)

An Interprofessional Perspective on Culturally Responsive Practice in Refugee Health

In a diverse society, healthcare cannot be based on the principle of one-size-fits-all, since patients from diverse social and cultural backgrounds may have unique health needs, expectations, and experiences. Cultural competence has long been seen as an ongoing process of recognising, valuing and respecting difference (Campinha-Bacote 1999), "through which one develops an understanding of self, while developing the ability to develop responsive, reciprocal, and respectful relationships with others" (Battle 2000). However, as Minnican & O'Toole (2020) point out, the term "culturally-responsive practice" has been more strongly favoured in recent years as it "implies the ability to accommodate the cultural needs of the service user rather than being able to function without error in their culture."

Culturally-responsive interprofessional practice in refugee health involves a wide range of healthcare professions working together as a team to provide empathetic, respectful person-centred care that is seen as an approach to contribute to equal health opportunities. This includes understanding influences on service delivery at micro, meso and macro level and how these can be navigated:

Culturally responsive practice is characterised by recognising the diversity of individual life experiences and cultural or linguistic backgrounds of patients in diagnostics, treatment and counselling. It is based on an open, appreciative and empathetic attitude that takes into account their individual needs and perspectives. This also requires sensitivity towards one's own cultural influences and their potential impact on service provision. Culturally responsive practice is characterised by attentiveness to different barriers that could have a negative influence on service delivery or prevent its results from being relevant to the patients' lifeworld, and looks for ways to minimise or overcome these barriers. It also includes avoiding stigmatising or stereotyping language patterns that could affect patients' identity or

self-image. Beyond the immediate therapy situation the specific social context of the clients or patients as well as to the institutional context of service provision are also considered. This demand for analytical skills on the mezzo and macro level on the part of the healthcare professionals leads, for example, to a new understanding of therapeutic interaction as collaborative relationship-focused practice (Restall & Egan 2021).

With regard to this critical collaborative interaction, the approach of cultural humility was conceived in 1998 by the physicians Melanie Tervalon and Jann Murray-García as a counter-concept to the widely accepted didactic models for developing cultural competence. They understand cultural differences as an inherent element of the relationship between the equal perspectives of health care providers and clients. According to Tervalon and Murray-García (1998, p. 117), cultural humility involves a lifelong commitment to self-assessment and self-criticism. With regard to people with refugee experience, this means being continuously in a culturally sensitive, critically reflexive process in order to examine dynamics between health care provider and client, to perceive power imbalances and to consciously counteract them. Power imbalances can arise, for example, because the people involved in the therapeutic process have a different understanding of their roles. This includes paternalistic experiences in the health care system. A flexible and humble attitude that develops in a lifelong process of self-reflection enables health care professionals to let go of the deceptive feeling of security that arises in a stereotype-based interaction, to assess a situation individually and, if necessary, to admit their ignorance in order to then embark on a search for new resources that can contribute to improving their future professional practice (cf. ibid., p. 119).

Exercise: Interprofessional Culture Tour

Get together with other learners to form a group that includes professionals from three different disciplines. Imagine that you are relocated as health professionals to the country of Utopia, which is completely foreign to all of you.

- What information about this country do you need in order to have a basic understanding of its health care system?
- What information do you need to be able to get help with a health problem?
- How would you introduce your profession to strangers in this country so that you could be assigned a meaningful professional role in its health care system?
- How does cultural humility help you in this process?

Summarize within your interprofessional team what you learned through this task and present a visualization (e.g. PowerPoint) of your results.

References:

Battle, Dolores E. Becoming a culturally competent clinician. *Special interest division 1: Language, learning and education* 7, 2000, 20–23.

Campinha-Bacote, Josepha. A model and instrument for addressing cultural competence in health care. *J Nurs Educ*. 1999 May;38(5):203-7. doi: 10.3928/0148-4834-19990501-06

Minnican, Carla, O'Toole, Gjyn. Exploring the incidence of culturally responsive communication in Australian healthcare: the first rapid review on this concept. *BMC Health Serv Res.* 20, 20 (2020). https://doi.org/10.1186/s12913-019-4859-6

Restall, Gayle J., Egan Mary Y. Collaborative Relationship-Focused Occupational Therapy: Evolving Lexicon and Practice. *Can J Occup Ther*. 2021 Sep;88(3):220-230. doi: 10.1177/00084174211022889

Tervalon, Melanie, Murray-García, Jann (1998). Cultural Humility versus Cultural Competence. A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. *Journal of Health Care for the Poor and Underserved* 9(2): 117–125. doi: 10.1353/hpu.2010.0233

Case Studies: Culturally responsive Interprofessional Practice in Refugee Health

Review Bara`a, David or Sergey's stories - 4.1.2 Case studies: Culturally responsive Interprofessional Practice in Refugee Health. Get together in a small interprofessional group, choose one of the narratives and discuss the following questions:

1. Reflect on the roles played by the various participants in the situation. What intentions guide their actions and procedures?
2. How can the behaviour of Bara`a, David or Sergey be explained from a culturally responsive perspective?
3. What do you need as an interprofessional team to know to create a safe space for this individual or family?
4. Which cultural backgrounds resulting from the interprofessional team members' own personal socialisation could be assessed and understood quite differently by people with a refugee background?
5. How can you enter into this relationship with cultural humility?
6. How would you as a interprofessional team help and support a patient who suffers from fear associated with forced migration? What is your role as a professional in the team in this situation?
7. What could person-centred care mean in the situation of Bara´a´s and Sergey´s family and in David´s situation?
8. Please develop a step by step-plan for an interprofessional approach to build a relationship that is culturally safe, traumainformed and anti-oppressive.
9. From your respective professional perspectives, consider which tasks of this plan you could competently complete as a team member and share your thoughts on them.

Recommended further reading:

The following two reviews show the demands for (and gaps in) culturally responsive healthcare from provider and patient perspective:

Grandpierre, V., Milloy, V., Sikora, L. et al. Barriers and facilitators to cultural competence in rehabilitation services: a scoping review. BMC Health Serv Res 18, 23 (2018). https://doi.org/10.1186/s12913-017-2811-1

Minnican, Carla, O'Toole, Gjyn. Exploring the incidence of culturally responsive communication in Australian healthcare: the first rapid review on this concept. BMC Health Serv Res 20, 20 (2020). https://doi.org/10.1186/s12913-019-4859-6

4.1.1 Practice Experience: The Role of Occupational Therapists in Supporting Persons with Refugee Experience in Germany

Interview with Angelika Roschka, MSc

Please read the following interview with Angelika Roschka, M.Sc., who is an occupational therapist, lecturer in the Occupational Therapy programme at Ernst-Abbe-Hochschule Jena, University of Applied Sciences, and a trainer and coach for transculture, anti bias and democracy. Angelika has years of experience working with refugees in a small town in Germany. Prior to this, she worked as a community occupational therapist in Kathmandu, Nepal, and then in Cairo, Egypt, conducting and supervising the training of teachers in therapeutic assessment and intervention of children with special needs.

Occupational therapist's training already provides the therapists with transcultural competences, doesn't it?

Theoretically, you could see it that way, insofar as the training provides understanding and teaches diversity as a cross-cutting theme through all modules. From my practical experience, transcultural competence is multi-faceted, highly complex and a lifelong learning process. Somewhere I once read the sentence: "No one can know everything about everything at any one time." For me, this describes very aptly the learning mission that transcultural action implies. I don't like the term "competence" so much, because a competence would be measurable at some point. In my understanding, however, there can be no such thing as a certificate for being "transculturally competent", because there are no blanket recipes, no "do" and "don't" lists, no matter how much we may long for them in our dealings with diverse clientele. Rather, I find the term "transcultural learning" more appropriate. Every encounter with people – including those who seem "foreign" to us because of our own conditioning – offers an opportunity for learning. Every person has a "universe of cultures" within them that changes over time and can sometimes be contradictory. This includes e.g. symbols, rituals, value assumptions and beliefs, as well as all routines and habits of activity in everyday life. In a transcultural encounter, two universes meet. There is communication (verbal, and crucially also nonverbal) and it is almost impossible for this not to be a learning task. We cannot know exactly why our counterpart thinks, feels and acts the way she/he does.

So does transcultural competence mean the willingness to open up to cultural differences?

Besides differences, there are always similarities that I notice when I look closely. And it means having the openness to embrace the uncertain. It implies the willingness to let one's own world view "collapse" – if necessary several times a day. And that means triggering the process of transcultural learning within oneself and reducing that diffuse fear of losing control that is so inhibiting.

How do you convey this? How do the participants in your courses learn this?

The process of transcultural learning in an occupational therapy context shows itself in a socially successful interaction with culturally diverse clients. I do not understand culture as something that results purely from a person's national or ethnic origin, but as emerging in relation to different diversity dimensions, such as age, disability, sexual identity and sexual orientation or socioeconomic background. And when we talk about diversity, it always means at the same time to consciously deal with discrimination, even if this is not easy for us to accept and to speak about. Discrimination (at conscious or unconscious level) always leads to devaluation and exclusion. Thus, in my current educational work, the consideration of power relations in society is in the foreground, which is also a highly relevant context for occupational therapy services. As an occupational therapist, I reflect on this and ask myself, for example, through which cultural glasses I read my client's experiences, with which ear I listen to them and to what extent I (unconsciously) practice attributions. It is the permanent confrontation with client orientation and interactive reasoning that we seem to have internalised. But since we are not free of prejudices, there is a constant danger that we will not do *justice* to people in the truest sense of the word due to societal structures, our own influences and the socially constructed boxes we are used to thinking in. This is why it is important to be sensitive to the concept of prejudice awareness and to realize the connection between society and its individual members.

In my workshops, I invite the participants to take a look inside themselves in order to deal with the question "Where do I come from?“ - not primarly in a geographical meaning but from a social point of view. Looking at, becoming aware of and reflecting on one's own cultural imprints and experiences are an important building block of transcultural learning. For example, the way my parents actively involved me in family decision-making processes in my childhood days still influences my ability to formulate my own wishes today. When people grow up in a more collectivist context, ways of thinking anchored in society in terms of "we" rather than "I" categories may be prominent. What does this mean in terms of joint goal formulation with the client? How can the question "What is important to you personally?" affect different people? Does it make sense to them? Do we need alternatives beyond verbal language? In my workshops we discuss such questions and constantly refer to our own diverse cultural backgrounds. These processes of reflection makes us sensitive to our own privileges that result from our own cultural background and societal influences, as well as to experiences of discrimination that arise from unequal power relations. It broadens our view for the need to be empathic, e.g. in the everyday life of people with disabilities who - according to an inclusive understanding – are dis-abled by their environment rather than being disabled themselves. The ability to adopt a perspective (without claiming to really understand "the other") is fundamental.

Where do you see occupational therapy in the context of support for persons with refugee experience?

I definitely see occupational therapists as having a political responsibility to work with persons with refugee experience and other people who are experiencing daily occupational deficits on different levels – from occupational imbalance to occupational apartheid. Occupation is a human right! A large number of persons with refugee experience cannot pursue a self-determined everyday life with activities that are meaningful to them, because they are often accommodated for months or even years in collective accommodation centres – i.e. in an imposed setting with limited privacy. Instead, they experience occupational disruption, marginalisation and occupational deprivation – as international studies on displaced persons in refugee camps have shown. Theoretical knowledge about occupation, meaningful activities and their impact on quality of life, health and well-being is researched in the field of Occupational Science. However, in order to allow occupational therapists to truly act in a culturally

sensitive way, in-depth research practice is needed that includes all diversity dimensions of people, i.e. occupational therapists‘ clients, and tries to understand their activities in diverse contexts. In order to achieve occupational therapy services that are diversity-sensitive in the true sense of the word, and thus also discrimination-sensitive, the following is needed: further research on occupational therapy theory formation, specific qualifications for occupational practitioners, as well as an even broader anchoring of diversity topics and the associated discrimination in profession-specific educational curricula. In combination with community-oriented work, this offers enormous future potential for the profession.

How can occupational therapists get involved in this field?

I recommend that occupational therapists who want to make contact with persons with refugee experience for the first time approach social workers working in collective accommodation centres, but also caretakers and security guards, and start a conversation. Social workers are important contacts for occupational therapists, as they are very close to the people through the social counselling they offer and are familiar with the problems that affect the peoples‘ everyday lives in a camp. They work closely with staff in the authorities, such as the social welfare office or the foreigners registration office. It can be helpful to note down names (ideally of cooperating, friendly persons) in the authorities who can be important for accompanying persons with refugee experience to the authorities. Often there is also useful cooperation with interpreting services and it is valuable to know multilingual people for translation services. Political and church representatives of the municipality are also extremely important to the network for engagement with people with refugee experience. Who are the advocates here with regard to the issues of escape and asylum who honestly and publicly propagate an intercultural opening and support the complex process of the arrival of the diverse people in the best possible way so that the place of arrival can perhaps become a new home? And who are members of civil society who (want to) participate in this challenging process? Are there associations, initiatives, networking meetings and meeting places for exchange? I would like to encourage occupational therapists to get actively involved in building civil society initiatives. With a handful of people in the community, I was able to set up an initiative for "New Neighbours" in 2015 and thanks to many great (albeit fluctuating) supporters over the years, the initiative is still operating today and most recently won the Democracy Award (for its persistent commitment).

For a first contact with persons with refugee experience, I recommend occupational therapists not to proceed primarily goal-oriented (as we know it from the Occupational Therapy process), i.e. not necessarily and literally to have a suitcase with materials with them (according to the motto: "We are making Christmas stars today because it is December"), and not to think in advance about what exactly they could do. Some key questions for self-reflection can help, for example: Do I want to do something *for* persons with refugee experience? In a helping or supporting role? What do I expect from this? Do I want to do something *with* persons with refugee experience (in the sense of interacting at eye level and with the understanding that everyone has a contribution to make)? It can be helpful to remember that in the context of escape and asylum we meet people who are currently stuck in a chronic waiting loop and whose lives are primarily characterised by uncertainty. I do not know their interests, experiences, narratives, but I open myself with awareness of my own prejudices. Accepting the invitation to a cup of tea – as I learned during my work assignments as an occupational therapist in Nepal and Egypt – is a central key to building a relationship. I can offer myself as a listener and a contact person who takes the time to grasp what role meaningful action and meaning-making plays in the lives of persons with refugee experience. I can try to shape their everyday life together with them (within the

framework of legal regulations) and gradually fill it with meaningful activities. I can be a bridge builder who helps them to arrive in the country of arrival and its society, to gain a foothold, to act in a self-determined way and – ideally – to find a new home.

What do persons with refugee experience need?

Persons with refugee experience have a wide range of wishes, needs and desires. Sometimes a trauma covers up those wishes and longings. In the area of activities of daily living, there are needs that they – due to the current deficit of a common language – are unable to communicate, or often only rudimentarily. Can you imagine being forced to leave your home country and to stay in a totally new place where you don‘t know anything at all about its culture? Some needs of newly arrived people may seem quite banal to us. It is part of everyday life in a collective accommodation centre that you will meet people who approach you with a letter from the authorities or a health insurance certificate. Gestures are used to articulate that the person does not know what to do at this point. The person doesn't understand the document and may not know what to do next. And they may also need someone to talk to a doctor on the phone and make an appointment. Accompanying them to the authorities or to medical facilities is a great support, especially in the first months of the asylum procedure, when language courses have not yet started or have only just begun. A "short line" to medical staff who cooperate easily and their willingness – despite the fact that language translation is often lacking – is enormously helpful, especially in acute situations and in the case of chronic illnesses of people who need multiple accompaniment.

The everyday life of the new arrivals poses countless challenges because it takes place beyond a familiar environment: Where can food be bought that caters for a variety of religious backgrounds and related dietary habits? Is there a prayer room in the collective accommodation or somewhere else? What is the imposition of sanitary facilities and communal kitchens shared by many? Where do voluntary language courses or homework supervision for the children take place – beyond the state-subsidised ones? Where can one simply sit down in peace and quiet outside the room shared with many others? Where is access to free Wi-Fi so that you can stay in contact (possibly even undisturbed) with your family in your country of origin? Is there a locality or open space to meet natives and persons who have already settled in the new place who can show places to go for a walk, relax, spend time in a pleasant way? By visiting the accommodation, the occupational therapist can get an idea of the situation and identify the needs and problems of the people living there that can be addressed. The approach can be "classic occupational therapy" and in the sense of a culturally sensitive and diversity- and discrimination-conscious client orientation: Which activities are problematic in the everyday life of the people living in the facility? How important are these activities to them? How satisfied are they with their performance? This is illustrated, for example, by the following words of a woman with refugee experience in a collective accommodation centre: "Because of the four children, I can't take part in the language course that my husband has been attending for a few months. Soon he will take his first language exam. One of my children has a mental impairment. I have only learned a few German words so far. Yet I worked as a teacher in my home country. I loved it. How can I go on?“ With the residence title, there are growing challenges for people. When someone with a “foreign-sounding“ name is looking for a flat, it is not uncommon for this person to encounter prejudices and be hindered or prevented from access tot he housing market. The same may happen in the application process in the labour market – the hurdles for people who are considered “foreign“ are enormous – despite the fact that some persons with refugee experience have occupational training or university degrees, which are put to the test in lengthy recognition procedures and do not

always bring about successful integration into the labour market. Opening a bank account, which is a condition for employment, stands and falls with the attitude of the bank employees.

At all levels of society, it is important to stimulate institutional opening processes so that participation is made equally possible for everyone and – from the occupational therapist's perspective – the claim of occupational justice can be guaranteed. As an occupational therapist who takes on political responsibility, I act as an advocate for occupational rights and demand what people in their diversity are legally entitled to. The prerequisite for this is that I see myself as a member of the majority society, who is privileged simply because I don‘t face these barriers regarding societal inclusion in many respects.

Do you have a wish regarding your occupational therapy colleagues?

I would like to encourage occupational therapists in Germany to start supporting persons with refugee experience in a way that is sensitive towards culture, diversity and discrimination. This requires us to become aware of the fact that it matters whether people are read as e.g. "white" or "black", as homo-, hetero-, bi-, trans-, inter-, queer-sexual or as a person with a disability and not as a person hindered by environmental conditions. With all the appropriate criticism of westernised occupational therapy’s (in)compatibility with the needs of people from all over the world, we can focus on something that connects all people globally and is thus universal common ground: we all have an everyday life with diverse activities, we all shape everyday activities and routines, whether we actively reflect on this or not. We are confronted with specific everyday wishes, needs and occupational imbalances, even if these may vary strongly between people. What can occupational therapy contribute to ensure that occupational justice does not remain the privilege of parts of society?

If we as occupational therapists become involved as advocates for occupational justice and – even beyond a medical diagnosis – sensitively accompany people with refugee experience or/and persons from other vulnerable groups in their everyday lives and support the process of arriving in a home, which may eventually become a true home for them, then occupational therapy is fulfilling its political responsibility. It helps to shape a pluralistic society with its core competence in supporting occupations, which allows all people to *be* themselves in their everyday lives, to *do* something meaningful, to feel they *belong* and to *become* the person they want to be in future.

Questions:

1. How does Angelika Roschka describe the unique professional perspective, role and approaches of an occupational therapist supporting persons with refugee experience?
2. Which examples does she provide that illustrate the connection between the concepts of culture, diversity and health equity described in the introduction?
3. If you are an occupational therapist: would you describe the occupational therapy perspective on working with persons with refugee experience in your own country in a similar way? If you are from another health profession: what unique professional perspectives, roles and approaches does your own profession bring to interprofessional teams?
4. What kind of interprofessional collaborative practice does Angelika Roschka mention? In addition to that, which other types of culturally-responsive interprofessional collaboration in refugee health can you describe?

Case studies: Culturally-responsive Interprofessional Practice in Refugee Health

Narrative 1:

Bara'a and her family fled their home in Syria and currently live with her husband and three children in a refugee shelter in Berlin. Bara'a is still traumatized by the birth of her youngest child, Rouba, four years ago. Her hands tremble when she thinks back to that time. Unable to breastfeed her daughter due to psychological exhaustion, Bara'a relied on donations to buy breast milk for Rouba. When the donations ran out after a week, Bara'a had no choice but to feed her newborn with a mixture of sugar and water. Rouba has two older siblings. During Rouba's pediatric examination, the pediatrician notices that Rouba's development is delayed and she tries to talk to Bara'a about the child's situation and the plan for possible therapeutic support by occupational therapy, physiotherapy and speech therapy. Bara'a barely speaks German and looks at the doctor anxiously, nodding repeatedly in conversation. After a few minutes, Bara'a leaves the room and holds her daughter tightly against her. She does not show up for the first scheduled appointment of the therapy.

(Inspired by https://www.globalgiving.org/learn/listicle/13-powerful-refugee-stories/)

Narrative 2:

David flees from Gambia with his brother. The brothers' family collects all the money at their disposal to make their escape possible. They flee in a boat across the Mediterranean. David's brother drowns during the crossing. David himself suffers from severe sickle cell anemia and a shoulder joint restriction. He could not receive adequate treatment in his home country. On the flight, the pain crises worsen. Once in Italy, David receives no health assistance in the refugee camp and continues to flee to Germany. Here he is accepted as an unaccompanied minor refugee in a residential home for young adults and receives support from a counselor who also helps him to receive good medical care. David then receives psychotherapeutic and physiotherapeutic therapy. David starts a nursing assistant training. The severe illness leads to repeated hospitalizations and severe pain crises. David fears that he will not be able to complete his assistant training and wants to discontinue it. He is particularly burdened by the recurring pain crises in everyday life, which he cannot hide from others and which are very unpleasant for him. He talks to the doctor about the situation. The doctor asks the supervisor, therapists and the head of the training program to meet with David for a joint discussion.

Narrative 3:

Sergey flees from Ukraine to Germany with his wife and their little son Yegor. The son is 5 years old. The family is staying with friends in Germany. The friends approach Sergey about the fact that the little son does not make any contact with them and does not even look at them. Sergey explains that his son has always been a bit slower in his development and he is loved by his wife and him the way he is. The friends recommend that Sergey be examined by a pediatrician friend who works at a social pediatric center. Since Sergey and his wife do not speak German, the family friend offers translation assistance. Reluctantly, Sergey and his wife follow the suggestion to go to the doctor with their son. The doctor has asked an occupational therapist and a speech therapist to come to the examination. The examining pediatrician, after consulting with the therapists, confronts Yegor's parents with the statement that their son suffers from an autism spectrum disorder and is in urgent need of treatment. The parents do not

understand the doctor and the translation of the friends. They ask many questions and want to know again and again why the child must be treated, their son is doing well and they are now safe.

Get together in a small interprofessional group (3-4 learners), choose one of the narratives and discuss the following questions:

1. Reflect on the roles played by the various participants in the situation. What intentions guide their actions and procedures?
2. How can the behaviour of Bara`a, David or Sergey be explained from a culturally responsive perspective?
3. What do you need as an interprofessional team to know to create a safe space for this individual or family?
4. Which cultural backgrounds resulting from the interprofessional team members‘ own personal socialisation could be assessed and understood quite differently by people with a refugee background?
5. How can you enter into this relationship with cultural humility?
6. How would you as a interprofessional team help and support a patient who suffers from fear associated with forced migration? What is your role as a professional in the team in this situation?
7. What could person-centred care mean in the situation of Bara´a´s and Sergey´s family and in David´s situation?
8. Please develop a step by step-plan for an interprofessional approach to build a relationship that is culturally safe, traumainformed and anti-oppressive.
9. From your respective professional perspectives, consider which tasks of this plan you could competently complete as a team member and share your thoughts on them.

4.2 Cross-Cultural Communication in Refugee Health

The relevance of effective communication in a diverse health system

How can health professionals deal with communication barriers in a resource-oriented and productive way? This chapter looks at a process which concerns not just individual health professionals and persons with refugee experience, but also policymakers and organizations responsible for setting up structures and services in the health system, including refugee organisations.

What is communication and why is it essential in healthcare?

Communication is the process of exchanging information, ideas, thoughts, and feelings between individuals or groups through various mediums and channels, generating meanings within and across contexts and cultures. It is a fundamental aspect of human interaction and vital to achieve understanding and convey meaning in personal relationships, organizations and society as a whole. Communication can take various forms (including verbal, nonverbal, written and visual). Health care professionals must get to know their patients by understanding their cultural and linguistic backgrounds to ensure that they

provide appropriate care. Effective communication is an essential basis for the development of good interpersonal relationships and contributes to more effective service provision in healthcare, which increases the chances for improved outcomes and attainment of goals.

Understanding communication in a diverse society

A resource-oriented approach to addressing language barriers in healthcare recognizes the value of multilingualism and linguistic diversity. Instead of framing language barriers as a negative aspect of care, a resource-oriented approach emphasizes the importance of language access as a resource for improving the quality of care and promoting positive health outcomes. One way to express this approach is to focus on language access as a valuable resource for enhancing communication and building trust between healthcare providers and patients. Another way is to focus on the benefits of language access for promoting patient autonomy and empowerment. In today's culturally and linguistically diverse society, two essential guiding principles can provide the foundation of culturally responsive communication in healthcare:

1. The concept of **inclusive communication** represents a process in which different strategies are applied to allow people with communication vulnerabilities to feel acknowledged and respected in the communication and to become actively involved in society. Consequently, inclusive communication is adapted to the individual communication strengths and needs of the persons seeking information and requires accessible individualized resources together with appropriate communication partners that have the necessary skills, knowledge, experience and attitude (Money et al. 2016).

2. The concept of **inclusive multilingualism** values the interactive strategies or communicative modes applied by participants in multilingual interactions who use different means to achieve mutual understanding (Backus et al. 2013). This recognises the importance of linguistic diversity and acknowledges that all communication partners contribute to efficient communication. In the context of refugee health this could mean affirming and valuing the patients' cultural backgrounds, prior experiences and linguistic resources as a contribution to patient agency.

3. **The need for effective communication in migrant and refugee health**

Communication plays a crucial role in the context of refugee health as it promotes understanding, addresses the specific needs and challenges faced by persons with refugee experience and facilitates delivery of appropriate health services. Cultural and linguistic barriers reinforce the power asymmetry between service provider and service users and lead to decreased adherence to treatment plans or to a patient's unwillingness to participate in rehabilitation treatment. On the contrary, if patients are given the opportunity to adequately express their symptoms and treatment wishes, unnecessary examinations can be prevented, which are often carried out because clear communication could not be established (especially with regard to symptom and complaint descriptions). At the same time, it is possible to be more responsive to the patients' treatment wishes (Peters et al. 2014). A literature review by Kwan et al. (2023) showed that "patients receiving 'language discordant care' are more prone to adverse events and potentially life-threatening conditions at different stages of hospital care including delay in treatment diagnosis at admission, poor communication for surgical procedure and at discharge which inevitably lead to hospital readmissions and an increase in healthcare costs."

Exercise:

Have a look at the article by Pandey, Mamata, Maina, R. Geoffrey, Amoyaw, Jonathan, Li, Yiyan, Kamrul, Rejina, Michaels, C. Rocha, Maroof, Razawa. Impacts of English language proficiency on healthcare access, use, and outcomes among immigrants: a qualitative study. BMC Health Serv Res. 2021 Jul 26;21(1):741. doi: 10.1186/s12913-021-06750-4, available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8314461/.

On page 6 you can find a figure illustrating the effect of insufficient language proficiency on healthcare provision for immigrants (= Figure 1: Language Proficiency Leads to Poor Healthcare Access, Suboptimal Care, and Dissatisfaction with Care).

1. Do you know these factors from your own work?
2. Do additional factors need to be taken into account in the area of refugee health?
3. Which strategies could help to address

- the ability of persons with refugee experience to access health information and services?
- the ability of persons with refugee experience to develop a therapeutic alliance with healthcare providers?
- challenges associated with engaging language interpreters?
- existing gaps in healthcare provision and improve health outcomes?

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Money, Della et al. (2016). Inclusive Communication and the Role of Speech and Language Therapy. Royal College of Speech and Language Therapists Position Paper. RCSLT: London. This document is available from the RCSLT website: www.rcslt.org

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Strategies for Effective Cross-cultural Communication in Refugee Health

Setting up culturally responsive structures and services

If patient care is to take into account the cultural backgrounds of patients from the perspective of self-determination and equity, appropriate structural conditions must be created. Without suitable structures and space to implement measures, even culturally responsive staff cannot act effectively. Uniform, universally applicable structures must be created at all organisational levels in which culturally responsive patient care is standard (Peters et al. 2014). Measures should include increase of workforce

diversity, implementation of structural analysis, and competence in planning, policy and practice (Spitzer et al. 2019). The scoping review by Grandpierre et al. (2018) found that patients and caregivers expressed an appreciation for services that incorporated cultural awareness into practice protocols. This involved services that used culturally appropriate materials and tailored care to meet their needs. Another recommendation was extending the appointment times for patients who do not speak the service language.

The Health Evidence Network (HEN) is an information service for public health decision-makers in the WHO European Region. In 2018 it published the following report: "What strategies to address communication barriers for refugees and migrants in health care settings have been implemented and evaluated across the WHO European Region?" (McGarry et al. 2018). The report contains the following policy recommendations (McGarry et al. 2018, ix):

"The main policy and practice considerations based on the findings of this review in the WHO European Region are to:

- ***encourage collaboration between statutory health care organizations, nonstatutory organizations such as NGOs with an interest in migrant health, and academic institutions to develop and implement strategies to address communication barriers for refugees and migrants in health care settings;***
- ***establish intersectoral dialogues on cultural mediation and interpretation among academic, policy, health care and professional organizations and NGOs concerned with refugee and migrant health to:***
  - ***clarify the terminology used to describe the role(s) of mediating and interpreting, and***
  - ***develop and implement consistent systems across countries for training, accreditation and professionalization;***
- ***provide training for health care staff in working effectively with cultural mediators and interpreters in cross-cultural consultations with refugees and migrants;***
- ***ensure the use of professionals who have been trained and accredited for mediating and interpreting roles in health care settings;***
- ***establish incident reporting systems in health care settings where strategies to address communication barriers are being implemented to provide a system level mechanism for reporting, monitoring and responding to problems and barriers to implementation;***
- ***involve migrants in developing and implementing strategies to address communication barriers; and***
- ***develop a national policy that emphasizes the importance of formal strategies to effectively address communication barriers experienced by refugees and migrants in health care settings."***

Cross-cultural Communication strategies at the interpersonal level

Effective communication forms the foundation for culturally responsive care, establishing mutual understanding and fostering patient engagement. Collaborative strategies are instrumental in promoting patient engagement and building partnerships. Key strategies involve comprehending the patient's overall situation, tailoring practices to suit the individual's circumstances and ensuring the patient's comprehension of therapeutic procedures. Patients recommend that practitioners be aware of language barriers and speak slowly to ensure comprehension (Grandpierre et al., 2018). In cases where language barriers persist, alternative forms of communication, such as nonverbal cues, gestures, or drawing, may be necessary to gather information.

In addition, according to the review by Grandpierre et al. (2018), patients and caregivers emphasize the significance of their relationships with healthcare practitioners and the need for collaborative partnerships within those relationships. They value practitioners who share information about their lives, including social, cultural, and historical aspects. Patients and caregivers also express the importance of having a consistent therapist to facilitate long-term relationships. It is often beneficial when the practitioner shares a similar cultural background or gender, as they may be perceived as more familiar with cultural taboos. However, it is worth noting that some patients also express concerns about maintaining confidentiality within their communities when such facilitators are present (Grandpierre et al. 2018).

In situations where refugees and staff are under pressure, maintaining a friendly, patient, and attentive demeanor may prove challenging. Various factors, such as anger, insecurity, fatigue, and pre-existing prejudices, can impede refugees' ability to express themselves, while also hindering staff members' active listening and respectful actions. Additionally, the power imbalance between refugees and staff can limit open communication, create unrealistic expectations, and heighten tensions (UNHCR, n.d.).

When communication problems remain unresolved at the institutional level, it can lead to frustration, which negatively impacts subsequent patient encounters. Barriers that hinder healthcare professionals from fulfilling their professional roles increase the likelihood of patients experiencing discrimination and mistreatment (Lewicki, 2021).

Exercise:

The UNHCR published a document with tipps and strategies for effective and respectful communication in forced displacement. Please have a look at this document, which is available at: https://www.refworld.org/docid/573d5cef4.html

Read the key considerations at the beginning of an intervention and the key considerations during an intervention.

Questions for self-reflection:

Think of the way interactions with patients or service users are typically organized in your workplace:

- Which of the UNHCR's recommendations do you already observe?
- Where would micro- or meso-level changes be needed to enable you to implement the suggested actions?

- Where would you need support from other professionals, volunteers etc. to enable you to follow the strategies recommended by the UNHCR?

To facilitate meaningful interaction and communication with persons with refugee experience, several main strategies can be employed:

- use the services of a translator or interpreter (this will be explored in a separate section below)
- utilize translation tools or services
- utilize nonverbal communication
- use visual aids
- invest in language learning

Utilizing translation tools or services

There are numerous digital resources, such as translation software and apps, that can provide quick and convenient translations for simple conversations. However, it is important to recognize the limitations of these tools and seek professional translation or interpretation services for more nuanced or critical discussions.

Experiment with your own phone: Try Google Translator, DeepL or other translation apps by typing in sentences, or using voice input. Try to use simple language in your native language. Try a language you speak and check the translation for errors. The further the language you try is from English, the more errors will occur.

Utilizing nonverbal communication

While language is a primary means of communication, nonverbal cues, such as facial expressions, gestures, and body language, can also convey meaning and facilitate understanding. Utilizing these cues, particularly when combined with limited shared language, can help to bridge gaps in communication.

You can watch the following animated video (4.40 min) explaining the concept of positive body language: https://www.youtube.com/watch?v=6vT6sqjBFrs&ab_channel=KristenOber

Please note that this video does not include a cross-cultural perspective.

Using visual aids

In addition to verbal communication, visual aids such as pictures, diagrams, pictionaries and other written materials can help convey meaning and facilitate understanding. These tools can be particularly useful in situations where language barriers are severe or when working with individuals who may have limited literacy skills.

You can find specific software for pictograms used in your country. This is an example from Germany. Have a look at the video on the site to get an impression of how to use pictograms: https://www.metacom-symbole.de/#

Another internationally used picture communication symbols is boardmaker: https://goboardmaker.com/pages/picture-communication-symbols

You can also use booklets with pictograms. Here is an example of a translation help for Ukrainians: https://piktuu.com/en/translation-aid-with-pictograms-for-refugees in German, English and Ukrainian. You can order the booklet or use the online version for free.

Investing in language learning

Learn a few words of the language as an icebreaker and facilitate deeper connections with individuals from different linguistic backgrounds. Learning a new language can also broaden your cultural understanding.

References

UN High Commissioner for Refugees (UNHCR), *Community-Based Protection in Action - Effective & Respectful Communication in Forced Displacement*, 2016, available at: https://www.refworld.org/docid/573d5cef4.html

Working with Interpreters and Cultural Mediators

A worldwide strategy to overcome linguistic barriers is the provision of professional services by interpreters or cultural mediators. These individuals are trained to accurately convey the meaning and intent of spoken or written language, ensuring that there are no misunderstandings or miscommunications. A review by Kwan et al. (2023) shows that the use of professional interpreters reduced interpretation errors that have potential clinical consequences and could improve understanding of discharge diagnoses; in contrast, the use of ad hoc interpreters or going without interpreter use altogether when the patient needed one increased interpretation errors. In other words, in situations where language barriers are particularly pronounced or the stakes are high, enlisting the services of a professional interpreter or cultural mediator is strongly adviced.

Whereas interpreters are typically only responsible for verbally translating spoken information from one language to another, cultural mediators facilitate mutual understanding by also providing advice on cultural understandings of healthcare issues. According to McGarry et al. (2018) cultural mediation has three main components: language interpretation, a responsibility to mediate cultural differences or facilitate intercultural communication and knowledge about a specific healthcare topic or health service.

ASHA, the American Speech-Hearing Association, has created a reminder that the interprofessional team should include a variety of experts to enable successful cross-cultural communication. Find out more here: https://www.thatsunheardof.org/learn-now/whos-on-your-cultural-iq-team/

Sometimes patients will refuse the use of an interpreter. There could be several reasons for this, and it may help to take some time to discuss and explain the role of the interpreter. Even if the patient says no, you can explain that you need an interpreter to ensure good communication. This may ease the situation and transfer the pressure of decision making from the patient to you.

Despite all the evaluations that show the positive effect of trained interpreters on preventing mistreatment, improving patient adherence and reducing healthcare costs, in many countries access to interpretation services is still limited for health professionals. As a consequence, these professionals are regularly obliged to enlist the help of lay interpreters, i.e. staff or family members. This has a massive impact on the quality of the service and thus on the quality of the content of the information. For example, Grandpierre et al. (2018) found that services that failed to provide an interpreter and assumed

that the patient would bring someone who could translate were seen as a barrier that could negatively affect attendance.

Many communities have organizations that specialize in working with refugees and may have staff or volunteers who are proficient in the languages spoken by refugees. Connecting with these organizations can provide a valuable resource for facilitating communication and supporting refugees as they navigate in the health system.

Using family members for interpretation services is generally considered to be highly problematic. Family members are emotionally biased and only pass on the content of conversations in an adapted form. Children in particular are exposed to content that is not suitable for them. In addition, unwanted role shifts in the family may occur.

Tips on how to work with an interpreter

As an introduction to the topic watch the following video by Sarah Clarke: "How to use interpreters effectively to create a healing environment: A guide for refugee service providers" (10 min.): https://www.youtube.com/watch?v=flB3DLEOsmg

ASHA, the American Speech-Hearing Association has published information on steps to take before collaborating with an interpreter to ensure a successful collaboration: https://www.thatsunheardof.org/learn-now/collaborating-with-an-interpreter/

Further information

Migrant & Refugee Women's Health Partnership. Guide for Clinicians Working with Interpreters in Healthcare Settings (culturaldiversityhealth.org.au). January 2019.

Migrant & Refugee Women's Health Partnership. Culturally Responsive Clinical Practice: Working with People from Migrant and Refugee Backgrounds (cbrhl.org.au). January 2019. Available at:

UN High Commissioner for Refugees (UNHCR), *Self-Study Module 3: Interpreting in a Refugee Context*, 1 January 2009, available at: https://www.refworld.org/docid/49b6314d2.html

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Self-Reflection Exercise

1. What is the situation like in your own workplace? Do you know how to contact available interpretion services or cultural mediators in your workplace or municipality?

2. Can you give examples of situations when you used an interpreter (or would have liked to use one)? Whose services did you employ (or could you employ)?

References

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The value of interprofessional collaboration in cross-cultural communication

When different health and non-health services work together and coordinate their efforts, it helps improve how service providers communicate and coordinate with each other to meet the needs of persons with refugee experience. The health sector plays a crucial role in collaborating with other organizations that deal with migration, social issues, welfare, education, and development. This collaboration is essential for promoting the health of refugees and migrants. Refugees often have complex healthcare needs, which means it's important to have a team of professionals from different fields working together. This kind of team helps organize and coordinate healthcare services to address the diverse needs of individuals requiring complex care (Iqbal et al. 2022).

As the European review by McGarry et al. (2018) highlighted, strategies were often put into action by teaming up people from different areas, like healthcare providers, community organizations, and academic institutions. These worked together to come up with plans that could be implemented in one place or spread across a whole region. Evaluation of these strategies showed in most cases that refugees and migrants gained better knowledge about health, improved their health habits, and got easier access to healthcare services. This shows how crucial it is for different sectors to collaborate and for regional and local authorities to create and carry out official plans that tackle communication issues faced by refugees and migrants in healthcare settings throughout the area.

According to Iqbal et al. (2022), there are nevertheless only very few interventions that focus on training or encouraging interprofessional teams in delivering healthcare services. This is in stark contrast to the fact that by working together, these different professions can ensure that patients receive

comprehensive, culturally-responsive care and help to identify and address systemic barriers to care, such as inadequate interpreter services or lack of access to culturally-sensitive health information. Healthcare professionals, such as physicians, nurses, allied health professionals, psychologists and psychiatrists can collaborate with interpreters; social workers and community health workers can, for example, ensure that …

- … service users understand their diagnosis, treatment options, and care plan;
- … service users and their families receive education and support;
- ... service users receive appropriate care and treatment;
- … service users receive support to navigate the healthcare system and connect with community resources and services;
- ... service users can advocate for their rights and work to reduce barriers to care;
- … service users who may be experiencing trauma, anxiety, or depression receive mental health services;
- … service users have access to health promotion and illness prevention.

Exercise: Preparation of information material

In small interprofessional teams, create posters that consider various aspects of cross-cultural communication in refugee health (see information provided in module 4.2). The posters should reflect the various professions represented in your small group with lots of imagery (pictograms, etc.) and few words.

Present your posters to the plenary and explain your choice of design.

Self-Reflection Exercise

What can you learn from others? In this short video, physiotherapist Philip Rynning Coker shares his ideas and experiences: https://www.youtube.com/watch?v=cinUwtgQHfo

- What is your own perspective regarding the value of interprofessional teamwork to overcome communication barriers when working with persons with refugee experience?

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For further insights review 4.2.1 Case studies: Interprofessional cooperation and how to use educational videos to improve interprofessional services.

4.2.1 Case studies: Interprofessional cooperation and how to use educational videos

Case Story: Interprofessional Cooperation

Please watch this video by the Philadelphia Refugee Mental Health Collaborative (PRMHC). Voices of Care: Promoting Wellness in Refugee Health – Communication (10 min.)

https://www.youtube.com/watch?v=sJ5nqghC6l0

In the video the following scenarios are shown:

- introduction to the patient
- navigating language barriers
- communicating the referral process

1. Which recommendations are given in the video? Are they relevant for your own work?
2. How does the video demonstrate the value of interprofessional cooperation in cross-cultural communication with persons with refugee experience?
3. Do you know any similar cross-cultural health networks in your own area?

Perhaps you have already worked with such a network. If not, do some research which health facilities, community services, refugee organizations etc. could help you to improve communication and interprofessional collaboration.

Answer the following questions:

1. How can you build trust and facilitate good communication in your work as a health professional? How important is good interprofessional teamwork for this?
2. How could interprofessional collaboration be improved to facilitate access to services for persons with refugee experience and to ensure better health outcomes?

Case Story: Improving Refugee Interprofessional Health Service Delivery with the Help of Educational Videos

In addition to direct interpersonal communication, the creation of culturally and linguistically appropriate education or information material can also be useful to increase the health literacy of persons with refugee experience and contribute to community empowerment processes. The case story described by Lokken and colleagues (2023) on "How Rohingya Language Educational Videos Help Improve Refugee Interprofessional Health Service Delivery in Milwaukee" will provide you with an example how this can be achieved. It is available at: https://journalofethics.ama-assn.org/article/how-rohingya-language-educational-videos-help-improve-refugee-interprofessional-health-service/2023-05

Additionally, have a look at the videos produced in the project:

https://www.youtube.com/channel/UC35cwxMBKJiR0CYELAWkbUw?view_as=subscriber

Questions to guide your self-reflection:

1. What was the issue at hand? Which cultural and linguistic barriers presented themselves?
2. Which different professions were involved in this initiative? How important was interprofessional collaboration to address cultural and linguistic barriers?
3. How important was the support by volunteers and community members?
4. Which steps were taken by the team?
5. How do you rate the outcome? What is needed to make it sustainable?
6. Do you know of similar collaborative projects in refugee health in your own area?

Reference:

Lokken J, Lee T, Mauer E, Wagner C, Sanders J, Oldani MJ. How Rohingya Language Educational Videos Help Improve Refugee Interprofessional Health Service Delivery in Milwaukee. AMA J Ethics. 2023 May 1;25(5):E365-374. https://doi.10.1001/amajethics.2023.365

Recommended further reading:

Blackstone, Sarah W., Beukelman, David R., Yorkston, Kathryn M. *Patient-provider communication: roles for speech-language pathologists and other health care professionals*. San Diego, CA: Plural Publishing, 2015.

Langdon, Henriette W., & Saenz, Terry I. *Working with interpreters and translators: A guide for speech-language pathologists and audiologists.* San Diego, CA: Plural Publishing, 2016.

Ethical Practice and Personal Conduct

Values and Ethics in Interprofessional Health and Social Care

While traditionally the adherence to ethical standards has been understood as a characteristic of individual health professions, the increasing prominence of team-based approaches in healthcare has led to a need for interprofessional discussion of values and ethics in this field. Attempts to create a collaborative value structure as a basis for the creation of cohesive healthcare teams rely on the following main approaches to interprofessional health care ethics: virtues shared by different professions, cooperation to provide health care as a right, and relationships grounded in values (Corr 2019). For example, the assertion of health care professionals as a moral community is based on the notion that health professionals have a joint obligation to care for the sick and need to work collaboratively to maximise health outcomes for their patients.

In her book *Interprofessional Ethics*, Donna McAuliffe (2022, p. 22) warns of the dangers of ethically illiterate teams or team members jeopardizing the provision of quality care to vulnerable people: “If a group of people working together do not understand client rights, informed consent, implications of privacy and confidentiality, how to treat people with respect and encourage self-determination and autonomy, or if there are unclear boundaries around professional relationships, harm can be caused.“

Human rights-based approaches focus on the rights of the individual and/or group in healthcare, which means that professionals need to know what these rights entail and need to be willing to support people fighting for them.

The Human Rights Act 1998 that came into force in October 2000 incorporates most of the rights protected under the European Convention on Human Rights (ECHR). According to Curtice & Exworthy (2010) a widespread lack of knowledge and understanding of the relevance of this legislation among patient and carer groups, health professionals and health management has led to the introduction of a bottom-up human rights-based approach that can be used by individuals and organisations alike in everyday practice. In essence, the idea is to protect human rights in clinical and organisational practice by adhering to the underlying core values of fairness, respect, equality, dignity and autonomy (FREDA) as the basics of good clinical care already provided by clinicians on a daily basis.

Viewing and Reflecting Exercise

Watch the following video by the Health Information and Quality Authority of the Republic of Ireland as an introduction to FREDA: HIQA: Human Rights in Health and Social Care Services. Available at: https://www.youtube.com/watch?v=9noiJnloIKc

1. Which factors in your own workplace allow you to adhere to these human rights-based core values? Which factors make this difficult?

2. Is this a bigger challenge when you work with persons with refugee experience?

An Ethical Perspective on Refugee Health: Working towards Health Equity and Social Justice

Social determinants of health in migrants and persons with refugee experience

The World Health Organization (2022) emphasizes that on the one hand, persons with refugee experience have a diverse range of physical and mental health needs, orginating from experiences in their country of origin, their migration journey, their host country's entry and integration policies, as well as their current living and working conditions. On the other hand, people with refugee experience are faced with enormous stressors related to social determinants of health, as they are widely excluded from access to fundamental human rights in a number of essential domains, such as healthcare, housing, education, employment and freedom of movement (WHO 2019). Additionally, migrants and refugees are increasingly exposed to violence and prejudice. In fact, discrimination has been identified as a major stressor and influence on the health of migrants in general and persons with refugee experience in particular. Healthcare systems, institutions and professionals are strongly influenced by historical, sociopolitical, economic, and legal contexts which facilitate the occurrence of discrimination and racism towards diverse groups of migrants and refugees. International research studies that address the question of how refugees and asylum seekers experience health services have reflected this. For example, respondents expressed the hope of not being disadvantaged because of their background and to be treated equally (Hahn et al. 2020). They emphasized the importance of a friendly and respectful attitude on the part of health professionals, as trust cannot develop without a sense of acceptance (Van Loenen et al. 2018). In particular the fear of stigma makes people with refugee experience afraid to accept medical care (van Loenen, 2018; Bahita, Wallace, 2007). "'Being an asylum seeker ... you feel people look at you as if you're not a human being [but] you're something different'" (Bahtia & Wallace

2007). This leads to a call for a change in attitude, not only in the health system, but in society as a whole, towards the situation of people with refugee experience.

The following video provides a refresher overview on the effects of migration on healthcare access and outcomes in countries of destination with a focus on the migrant themselves (8.50 min.):

https://www.youtube.com/watch?v=bNY2zGhJ2mQ

To increase your familiarity with the social determinants of health, you can watch the following video: What Makes Us Healthy? Understanding the Social Determinants of Health (6.30 min.): https://www.youtube.com/watch?v=8PH4JYfF4Ns

Health services for persons with refugee experience as a matter of social justice – the need for critical consciousness

Culturally responsive interprofessional practice in Refugee Health needs to be seen as a contribution to social justice. Kumagai and Lypson (2009) promote the development of critical consciousness as a framework that situates the health professions in a specific social, cultural and historical context and thus can help to achieve the provision of high quality, diversity-sensitive health services based on the recognition of the dignity and autonomy of all members of society.

Their description of critical consciousness does not only demonstrates the move away from outdated understandings of "cultural competency" in healthcare, but also illustrates the role of ethics in this context:

"The introduction of humanism, medical ethics, professionalism, and multiculturalism into medical education involves linking the professional training of physicians with human values, an orientation of education and practice towards addressing human needs and interests. Critical consciousness plays an essential role in these areas of medical education. From a pedagogic perspective, development of true fluency (and not just "competence") in these areas requires critical self-reflection and discourse and anchors a reflective self with others in social and societal interactions. By 'critical self-reflection,' we do not mean a singular focus on the self, but a stepping back to understand one's own assumptions, biases, and values, and a shifting of one's gaze from self to others and conditions of injustice in the world. This process, coupled with resultant action, is at the core of the idea of critical consciousness. In areas like multicultural education, professionalism, and medical ethics, the basic orientation of education and learning is fundamentally different than in the biomedical or clinical sciences or practice-related fields. In the biomedical or clinical sciences, the basic orientation is to build a foundation of knowledge to be applied in practice, but in fields seeking to incorporate humanistic values into medical education, it is directed towards fostering critical self-awareness, acquiring an understanding of social issues (both interpersonal and societal) in medicine, and developing an individual approach to reflective, ethical practice.

If we try to move beyond cultural competency and instead focus on the development of this critical consciousness, what is its object of knowledge? In other words, "What stuff should we learn?" The object of knowledge is not just a series of lists of cultural attributes (which can quickly degrade into dehumanizing stereotypes), nor is it a skill set of questions and demeanors we should assume when encountering a patient who is not like us. We propose that the object of knowledge of these educational efforts is the development of critical consciousness itself, that is, the knowledge and awareness to carry

out the social roles and responsibilities of a physician. This way of knowing is a different type of knowledge than that required when studying the biomedical sciences – complementary, but different all the same.“ (Kumagai & Lypson 2009).

Self-Reflection Questions:

1. According to Kumagai & Lypson (2009), critical consciousness plays an essential role in addressing human needs and interests. How do they argue their case?
2. How has critical consciousness played a role in your own education or professional work?

Human Rights Based Approach: A Self-Assessment Tool

Social justice means that everyone's human rights are respected, protected and promoted. Rights-based care in particular means recognizing the human rights of persons with refugee experience, promoting their dignity, and advocating for their health and wellbeing. The ability for health professionals to work across disciplines is seen as a critical step in promoting health equity based on the principles of diversity and inclusion (Worabo et al. 2022). Collaborating across professions can help to identify and address systemic barriers to care that may be impacting refugees‘ health and wellbeing, and advocate for policies and programs that support their needs.

Have a look at the “Human Rights Based Approach: A Self-Assessment Tool“ developed by the Scottish Human Rights Commission (2018):

“This tool is based on the PANEL principles (Participation, Accountability, Non-discrimination, Empowerment and Legality) which form the basis of a human rights based approach. It is intended to help organisations assess their work and identify priorities for improvement towards embedding a human rights based approach. It is likely that you will find that there are some areas in which your practice is already strong and assessing your organisation against these principles reinforces positive work. Using this tool allows you to identify areas where there may be gaps and to prioritise these for action. It can be used as a reference point, to keep track of how each aspect is improving. A human rights based approach will always be a work in progress and the idea is to progressively work on improvements until you feel comfortable that you are delivering on all elements – but this will take time!“

Exercise:

1. Read the assessment tool and reflect what a human rights based approach means for how healthcare institutions are organized and how health professionals need to act in their professional practice. Get together with another learner from a different profession and talk for 20 minutes about the following question: Thinking about the institution(s) where you work or have worked, what actions would be urgently needed to successfully address the needs of people with refugee experience based on a human rights based approach? Write down three bullet points to share with the plenary.
2. In your small interprofessional team spend another 10 minutes on discussing the following question: If you work for an institution that is concerned with providing health services to persons with refugee experience, how can you use this tool to check where a human rights based approach has already been implemented and how you can you use it to embed such an approach more vigorously? Write down two more bullet points to share with the plenary.

An Ethics Framework for Healthcare Services Provided to Refugees

As section 1.3 of this course ("Refugee rights are human rights") explained, persons with refugee experience are entitled to the rights and freedoms enshrined in international human rights instruments. At the same time, health professionals need to be aware of the fact that the legal rights and opportunities of people who flee across borders are not the same as those of the citizens of a country. Healthcare professionals consequently face the ethical obligation to carefully consider the precarious legal status of people in situations of forced migration. The situation of displaced persons is often determined by unequal power relations as they depend on the government, humanitarian sponsorship and/or service providers for survival and/or legal status. This extreme dependence can also impact their access to healthcare.

Reading Exercise:

Read the article by Ahmet Özdinç (2022) that addresses the healthcare needs of persons with refugee experience and the problems they encounter with healthcare services within the scope of an ethical framework. As part of this framework, Özdinç engages with

- the philosophical foundations of refugee healthcare, i.e. with the concept of rights and human rights;
- the ethical rules for health aid – as outlined by the Sphere Project; The People in Aid Code of Good Practice; The Code of Conduct for the International Red Cross and Red Crescent Movement and non-governmental organizations in disaster relief; and The Core Humanitarian Standard on Quality and Accountability (CHS);
- the principles of biomedical ethics (Beauchamp & Childress 1979/2019).

In his text the author particular focuses on the issue of limited resources in healthcare systems, which leads to the ethical tension that "although helping other people seems like a moral duty, whether this task is an obligation or a choice remains unclear" (Özdinç 2022, p. 15).

After reading this text should be able to differentiate the main foundations of an ethical framework for healthcare services provided to refugees.

1. How familiar were you already with them? How well do they relate to your own professional ethical framework?
2. Which ethical tensions (e.g. regarding resource allocation) does the article outline?
3. Can you develop an ethical position to substantiate your own professional praxis with the help of this framework?

A Capabilities Approach to Refugee Health

The "capabilities approach" was developed in the 1980s and 1990s by Nobel Prize-winning economist Amartya Sen and philosopher Martha Nussbaum, and initially refers to a general theory of social justice. Sen defines the core of the approach as "the possibilities or comprehensive capabilities of people to live a life that they can choose for good reasons and that does not challenge the foundations of their self-respect" (Sen 2000). It is therefore primarily a matter of determining what people need in terms of real

freedoms and material and cultural resources in order to be able to develop an autonomous life plan in a well-founded way and to be empowered to implement this life plan in practice.

Reading Exercise:

*To learn how the capabilities framework can provide an ethical framework for understanding and evaluating social determinants of health in persons with refugee experience, read the following article by Julie M. Aultman in the AMA Journal of Ethics: "*How Should Health Care Professionals Address Social Determinants of Refugee Health?"

Guide to self-reflection:

1. In her commentary on the case narrative, Julie Aultman looks at the general health conditions of resettled refugees and how this is influenced by the social determinants of health they experience. She also considers the recognition or violation of the refugees' rights (pp. 225-226). Can you transfer this analysis to a case of your own and to the healthcare system you work in?

2. According to Aultman (2019): "Part of a social justice analysis also includes identifying avoidable SDH that create unfortunate constraints on human capabilities." How is this illustrated in the commentary (pp. 227-228)? Can you apply this to your own case/your own healthcare system?

3. "To contribute to the change that is needed to promote human capabilities and overall patient health, health care professionals and organizations need to be advocates for their refugee patients by identifying barriers to care that compromise capabilities such as lack of transportation, health illiteracy, the inability to take time off work, and the high costs of quality care […]" (Aultman, 2019, p. 228). Can you link this statement to a call for interprofessional collaboration in refugee health?

4. Aultman (2019) sees a general ethical obligation of health care professionals and institutions to the community and to society at large and quotes the relevant ethical principles of her own professional association, the American Medical Association (AMA). How do the ethical guidelines of your own profession address this issue?

Research Ethics in Refugee Health

The underlying concern in ethical discourse regarding research in refugee health, revolves around the inherent power imbalance that invariably exists between researchers and refugees. This power disparity emerges from the vulnerable position of refugees juxtaposed with the privileged position of researchers. For refugee research participants, this vulnerability often stems from a combination of factors, including restricted mobility, diminished autonomy reliant upon non-governmental organizations, linguistic barriers, uncertain legal status both in the present and future (which increasingly involves potential criminalization), as well as the enduring impact of past and ongoing traumatic experiences. As a consequence, the researcher's approach in terms of planning, preparation, and practical implementation should be shaped in recognition of this power asymmetry and in an attempt to minimize its effects (Deps et al. 2022). The exclusion of refugees from research or public health investigations based on their vulnerability is not an option, as it contravenes principles of justice and fairness. Such exclusion would disregard the potential value of evidence derived from these investigations, which could inform targeted

interventions, validate models of health service delivery, and ultimately safeguard the well-being of individuals affected by displacement (Seagle et al. 2020).

The European Commission published a "Guidance note: Research on refugees, asylum seekers and migrants" in 2021. This document is available at:

The Importance of Personal Conduct in Interprofessional Refugee Health

The concept of personal conduct has its roots in healthcare ethics, a branch of applied ethics that examines the moral and ethical issues arising in healthcare. Healthcare ethics seeks to provide guidance and frameworks for health professionals to navigate complex ethical issues and make decisions that are in the best interests of their patients. Personal conduct refers to the ethical responsibilities and behaviors of individual health professionals. The principles of medical ethics, including the importance of personal conduct, are reflected in professional codes of ethics and guidelines for health professionals, such as those developed by various national medical, nursing and allied health professional associations. However, personal conduct is not just an individual responsibility, but also involves working collaboratively with other healthcare professionals to ensure that patients receive the highest quality care possible.

Interprofessional collaboration in healthcare involves healthcare providers from different disciplines working together to deliver comprehensive and coordinated care to patients. When healthcare providers work collaboratively, they can share knowledge, skills, and expertise, and develop a shared understanding of their patients' needs and preferences.

The primary focus of healthcare is the well-being and best interests of the patient. Personal conduct plays a crucial role in establishing and maintaining a therapeutic relationship that is based on prioritising the patients' needs and dignity. Personal conduct is an essential aspect of culturally-sensitive refugee health as healthcare providers who work with persons with refugee experience must be aware of their own cultural biases, beliefs, and values, maintain confidentiality, strive to approach their patients with cultural humility and respect and engage in effective communication.

Personal conduct significantly affects the trust between healthcare professionals and patients, as well as among members of the interprofessional healthcare team. Trust is vital for effective collaboration and the delivery of quality care. Ethical behavior, such as honesty, integrity, and accountability, helps build and maintain trust, fostering a professional environment.

In the context of culturally-responsive practice, personal conduct includes striving to understand the patients' experiences and perspectives, learning about their cultural beliefs, practices and values and addressing one's own biases and assumptions so that care can be adjusted to meet the patients' specific needs and preferences. Health professionals must also be aware of the potential impact of trauma on the physical and mental health of persons with refugee experience and approach their care with sensitivity and compassion.

Interprofessional collaboration is essential for providing comprehensive and integrated care. Personal conduct shapes the dynamics of teamwork and collaboration within healthcare settings. Ethical behavior promotes effective communication, active listening, mutual respect, and empathy, all of which enhance collaboration and lead to better patient outcomes.

Health professionals often encounter complex ethical dilemmas requiring thoughtful ethical decision-making. Personal conduct influences this process insofar as health professionals with a strong ethical foundation are more likely to consider the values and rights of patients, respect diversity, and adhere to professional codes of conduct when facing difficult choices.

Personal conduct can have a positive effect on the behavior and attitudes of others. Professionals who demonstrate ethical conduct set positive examples, inspiring others (students, colleagues, and other health professionals) to uphold high standards of ethics in their practice. This is particular important in the area of refugee health, which requires a professional, empathetic way of dealing with complex situations that can easily lead to the experience of moral distress.

Finally, personal conduct reflects the professionalism and integrity of health professionals and the institutions they work for. This is particularly important when health professionals aim to collaborate with refugee organizations. These will be more willing to contribute their to collaborate in joint initiatives to address the healthcare needs of refugees when they feel that they can rely on the health professionals seek to learn from their expertise.

Self-Reflection

1. The above text lists five essential reasons why personal conduct is important for health professionals in interprofessional refugee health. Do you agree? Can you think of others?
2. What are essential elements of personal conduct in your own profession? How did you learn about them?
3. Can you give examples of shared understandings of good personal conduct in specific team settings?

- How was this understanding reached or how was it communicated to new team members?
- Have any professions been particularly influential in this process?

Join the Module 4 Discussion:

Write a statement (200 words) on the importance of personal conduct in interprofessional refugee health that reflects your own experience and/or personal position. Try to include examples of situations that illustrate the importance of personal conduct. Post it in Module 4: Personal conduct in interprofessional refugee health.

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World Health Organization (2022). Refugee and migrant health (Fact Sheet). Available at: https://www.who.int/news-room/fact-sheets/detail/refugee-and-migrant-health

Recommended additional reading

The topic of ethical obligations of humanitarian health care organizations and health workers working in contexts of armed or violent conflict is not covered in this chapter. However, those interested in it can read the following overview:

Broussard, Grant, Rubenstein, Leonard S., Robinson, Courtland, Maziak, Wasim, Gilbert, Sappho Z., DeCamp, Matthew. "Challenges to ethical obligations and humanitarian principles in conflict settings: a systematic review." *Int J Humanitarian Action* **4**, 15 (2019). https://doi.org/10.1186/s41018-019-0063-x

Advanced Clinical Reasoning

Understanding health risks in different countries of origin of persons with refugee experience

Advanced clinical reasoning is the process by which healthcare professionals from different disciplines collaborate to understand and address the complex needs of patients. When working with people with refugee experience, this process can be particularly important, as they may have unique healthcare needs and may be facing challenges such as language barriers and cultural differences. Their potentially complex healthcare needs may require the expertise and input of multiple professionals. Interprofessional advanced clinical reasoning involves the ability to think critically and creatively, and to consider the potential long-term impact of different treatment options. The healthcare needs of people with refugee experience may be more complex and may require longer-term solutions.

When you first talk to your patient, depending on your work setting, you often know only the diagnosis on the doctor´s referral. The following chapter will guide you how to take more aspects into consideration. First open your mind for the health risks in different countries of origin of persons with refugee experience. Then you learn to describe the current components of your patient´s health using the International Classification of Functioning, Disability and Health (ICF). Finally you will take into account narrations of the past.

Reading and reflection exercise: Read the article The spoils of war and the long-term spoiling of health conditions of entire nations about the impact of war on a country's ability to provide healthcare services to its citizens. Please note the major medical consequences for the individual.

Open the data portal Refugee Health Profiles and look for the potential health profile of people from different countries just after arriving in the new country.

The life situation of people with refugee experience is complex and characterized by various factors that influence their lives. Knowledge and understanding of these factors is difficult for health care workers, because in most cases the circumstances are completely unknown and therefore more difficult to understand. Good interviewing, careful listening and special empathy skills are necessary to develop a sustainable client-therapist relationship in this context. Special attention must be paid to the context, which in most cases will be very new and perhaps unfamiliar for clients with refugee experiences.

Interprofessionality is essential in this process, as the different disciplinary perspectives contribute to a deeper understanding of the client's situation and allow the client more diverse ways of working together. The chance of successful collaboration is increased by interprofessionality. Therapists who have developed competencies in the area of role understanding, communication, teamwork and ethics in interprofessional collaboration can use these in the collaboration with clients and the team for the development of individually appropriate and sustainable care for people with refugee experiences. "Therapeutic teams work interprofessionally in this field to be able to address the multiple needs of refugees' health through multiple coordinate professional competences" (Adamopoulou et al., 2022, 74).

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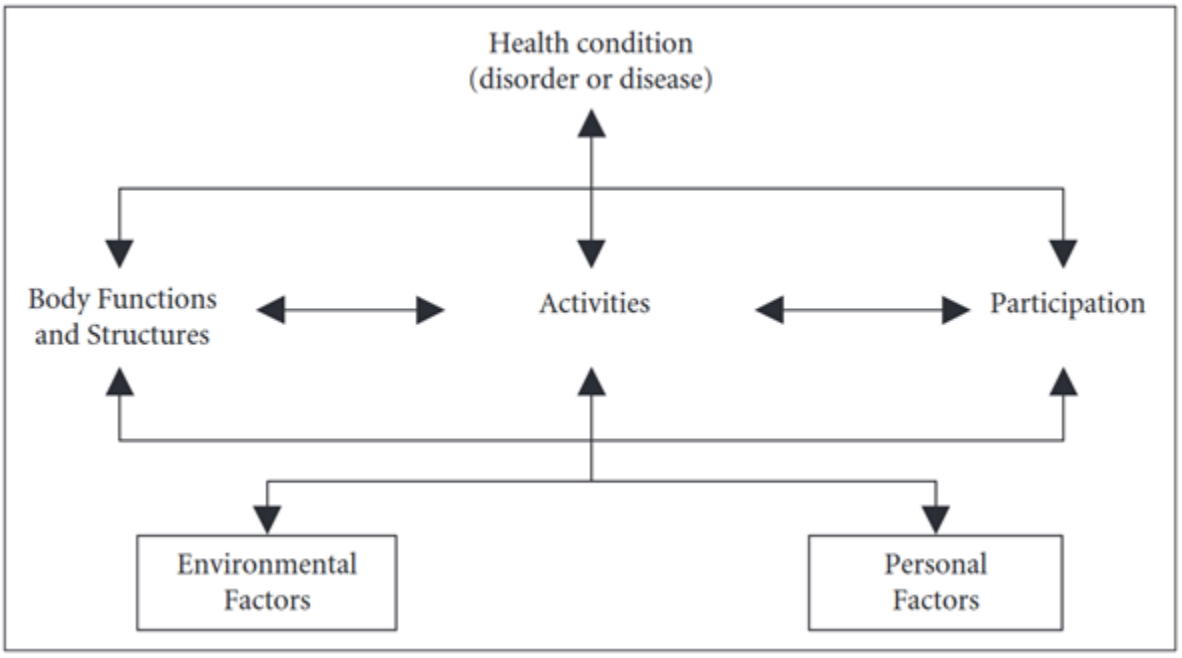
International Classification of Functioning, Disability and Health (ICF)

One key aspect of interprofessional advanced clinical reasoning is the ability to consider the patient's overall context and life circumstances, rather than simply focusing on their immediate healthcare needs. This includes taking into account factors such as social, cultural, and economic issues that may have an impact on the patient's health and well-being.

As a healthcare professional you will probably be used to working with the International Classification of Functioning, Disability and Health (ICF) (WHO 2001). The ICF describes the components of health to identify the constituents of health. You can use this model to understand the complex health situation beside the specific medical problem of people with refugee experience. Additionally the ICF provides a common language for describing health and health-related states that facilitates interprofessional communication.

Have look on the interaction between components of ICF:



(World Health Organization. (2001). International classification of functioning, disability and health: ICF. World Health Organization. https://apps.who.int/iris/handle/10665/42407)

Regarding the specific needs of people with refugee experience, healthcare professionals will focus also on the contextual factors such as environmental and personal factors to gain a better understanding of the current health problem. They play an important role in establishing a diagnosis and providing treatment. The ICF provides a list of contextual factors which help you to consider and classify contextual factors.

Watch the following video that explains the contextual factors of the ICF and provides you with an example how to use them (4:51 min)

https://youtu.be/-j0495iwCX0

Have a look at these tables of the ICF contextual factors to find more potentially relevant aspects for the person you work with. The ICF classification permits to assess these determinants of health systematically:

The ICF is an instrument for assessing the current components of health. It is not able to describe the history of the individual. Therefore you need to have an ear for narrations. To better understand the entire health issue at hand, the person's past as well as historical aspects of the environment should additionally be considered. A conversationally open attitude that allows for client narratives is the key to getting to know the person with their preferences and expectations. These narratives are very important for a meaningful alignment of the therapy measures to the individual's needs.

In addition to the meaningful use of the ICF, the use of other assessments is useful. Good interprofessional cooperation enables the coordinated use of profession-specific assessments. With their unique focus on the respective subject area of different health professions they can provide important findings that are beneficial for the interprofessionally coordinated therapy process. Interprofessional coordination of assessments prevents the duplication of assessment procedures as well as assessments that are inefficient and unnecessarily burdensome for the client. In addition, the coordinated use of assessments in the interprofessional team enables mutual knowledge of the processes for therapeutic decision-making and thus facilitates the development of an effective team reasoning process.

Module 4: Diversity in Society and in Health Care

Join Module 4 discussion on advanced clinical reasoning. Reflect on your own experiences. Choose a specific case. Include any barriers or challenges you experienced. Use advanced clinical reasoning to foster a better understanding of the entire person. Use the ICF to get an idea of the different aspects and components of health. Add aspects regarding the past if relevant. Post your contribution (200 words) to this Module 4 Discussion: Diversity in Society and in Health Care. Follow the posts of other learners and comment on at least one other discussion board post.

Integrating the narratives of persons with refugee experiences

For healthcare professionals working with persons with refugee experience, advanced clinical reasoning may involve considering the impact of factors such as trauma, displacement, and limited access to resources on the patient's health. It may also involve understanding the unique cultural and linguistic needs of persons with refugee experience, and working with interpreters or other language support services as needed.

Read Amira's story. Having read it, get together in an interprofessional group and have an exchange on the following questions:

1. When in your life have you ever felt that you could no longer pursue an activity, hobby or occupation or that others prevented you from pursuing it?

- What feelings did this trigger in you?

- What did you do about it?
- Who or what helped you in this situation?

2. Discuss these questions related to the situation Amira describes in her story:

- What prevents Amira from pursuing her activities and occupations?
- What feelings does she describe?
- What could Amira do about the situation?
- Who or what could be a help in the situation?

3. Share Amira's situation in relation to your specific professional focus (subject area). What concrete benefits can interprofessional cooperation bring for Amira?

4. Read the following article on occupational disruption:

Review the article by Helen Claire Hart (2023), Imagined futures: Occupation as a means of repair following biographical disruption in the lives of refugees, Journal of Occupational Science, 30:1,24-36, DOI: 10.1080/14427591.2022.2038249

- Summarise the key messages of the text.
- What further possibilities for supporting Amira arise from the text?
- Develop a series of statements about the connection between the consequences of trauma and language learning or other important activities.

Recommended literature:

Sodemann, Morten (2022). What you don't know will hurt the patient: Cross-cultural clinical medicine and communication with ethnic minority patients. Available at: www.ouh.dk/textbook

4.4.1 What language means to me: A personal story

About Amira's story

The following text was written by Amira* (*name changed), a 45-year-old free-lance journalist and children's book author from, Damascus, Syria, and a single mother of three children. In 2015, she fled Syria via the Balkan route with two of her children and came to Germany. It was only four years later that Amira managed to bring her middle son - shortly before his 18th birthday - to Germany via a family reunification procedure. For the first few years, Amira lived with her children in various refugee shelters in southern Germany. Since 2019, Amira has been living in her own flat with her 14-year-old daughter and middle son. Today, her sons live in shared flats in the same city.

Her co-author is Kerstin Berr, MSc, in Occupational Therapy, employed at Bosch Health Campus GmbH, Stuttgart. Kerstin wrote: In 2016, I met Amira and her family through my volunteer work in refugee aid and we became friends. Today we live in close proximity to each other and meet every week. While we only communicated in English in the beginning, we have exclusively been speaking German with each other since 2018. The text is based on our conversations. We recorded our conversation and I wrote it

down and summarised it. Together we discussed the text. It is only a small part of Amira's story, but an attempt to give her feelings a voice.

What language means to me: A personal story

I love writing! As a child I used to write and read the texts to my mother. If my mother thought it was good, it was good enough for me. If she didn't like something about my writing, then I wasn't happy either. I always tried to write. I often sat in my room for hours and created stories.

But it was a long way until I found my way to writing as a career. After my school education, I started a family early and spent the next years of my life taking care of my family and raising the children. During this time, there was little room for writing. But whenever I found the opportunity to take time out, I read and put my story into words.

When the children started school, I finally got the chance to work for an agency that produced children's books. They published books for children from 1 to 12 years old. My job was to check the texts first. During this time, a colleague of mine found out that I write texts myself and asked me if I could show her some of my texts. She read my texts and was enthusiastic. I told her that I only write for myself, without a bigger plan. She asked me if we could show the texts to our boss. And so I started writing for the publishing house.

I worked a lot during that time – copywriting, graphic design and I wrote my own stories on the side. But then the unrest in the country began and finally the war broke out. That's when I started working as a clandestine journalist. I travelled to places that were affected by the war and reported on the situation on the ground. I talked to many people and documented the crimes. It was very stressful work, but I wanted to help and give people a voice through my reports. The texts were then taken abroad. It was very dangerous work. After two years it became too dangerous and I was afraid for my children. My mother finally told me to leave the country.

Then the publishing house I worked for also left the country. In my office there was a drawer with all my written work. There were many notebooks that I had filled by hand. I only wanted these texts. It was my story – the story of my life so far. But I was told they were all destroyed. I didn't care so much about the children's books, but much more about my private texts. I didn't have a copy, it was all handwritten. But I didn't get anything back.

Then came the escape.

I fled with my youngest daughter and my older son. Actually we wanted to go to the Netherlands, but with a group of refugees we finally ended up in Germany.

At first I thought I could manage everything, learn the language quickly and catch up with my son within a few weeks. I thought I only needed one year and then I could work as a writer again – or so I had heard. You only need one year to learn the language and then you move on. But I experienced one trauma after another in Germany. The first camp was very bad. We shared a room with many other people, the food was very bad, we had little money and no idea what to do.

I had no orientation and didn't know what to do to change this state of waiting. It was very hard for me – always waiting. I was in the country for seven months without access to a language course. I tried to learn the language through YouTube videos. I learned a few simple phrases, like "My name is ..., I have

children...". I kept asking for a language course, but I was told that I couldn't take part in any language course without papers. When we moved to the next accommodation, my daughter got a place at school. Every day I had to take her to school and pick her up. It was only in the third accommodation after a year in Germany that I was able to start my first language course.

Before that, I could only communicate in English, and in the camps there were sometimes projects run by volunteers. When I heard about them, I went and learned a bit. That's why I was able to join the first official language course at A2 level. At first I was very good, but then I don't know exactly what happened. Maybe it was because I was very unhappy at the camp or because of my stressful situation? I had imagined everything so differently. Everything was incredibly difficult – learning the language, finding work, worrying about my children and the many foreign people around me.

And when I sought medical help, I had to understand everything that was said, but I didn't. That made me very angry and sad. But I swallowed my anger - all day long. All the difficulties in everyday life: with the social welfare office, the job centre, the situation of my children and I still had no residence status and no papers.

I didn't ask for help and instead tried to sort everything out in English, but my head was often too full. Too full to understand everything and I just felt sad. And I really tried to learn, but I don't know why what I learned didn't stay in my head. I've had the problem for a long time that I forget a lot. But I thought I could do it: I can learn German, I can work, I can start a new life. But I have lost that feeling.

I don't know. I tried to talk to a doctor, but it didn't help me. They don't have time to listen and help me and that makes me even sadder. I was recommended therapy at a counselling centre.

I wanted to try everything to make it better and I started a trauma therapy. There they tried to explain my situation to me. There is no certainty, but maybe I have a trauma and because of this trauma this blockage in the brain happens. My head wants to protect me and that's why I can't remember. I don't know.

One year after therapy I still have the feeling I am very deep down and I need a lot of time to come up again. And for that I need a lot of energy, a lot of strength and time. I hate it when I need help. I hate the feeling and so far I need a lot of help – with translations of letters from the authorities, with financial questions, just for everything and I hate this feeling. And I hate it when I have to ask my children for help. And it makes me sad and angry when my children say to me that I need to do more. I feel bad and stupid when I have to ask for help. My head is empty.

I have told a lot – talked a lot, a lot, because I want to help myself. And the therapists have said that this is good. It's good if I can talk about the past and they noticed that I have a lot of information about mental health problems. I said, "Yes, I am interested in this". And they said this is the first important step. I understood that right away and talked diligently. But I want to understand! Why do I have such a problem? I asked my mother, friends and the therapists. But they only said, maybe it's a big problem - maybe you saw a murder, for example, or it comes from my war experiences... – but maybe it's a very small problem, but very important for me and it broke something? And I answered "Excuse me, many people in Syria have experienced disasters, but they go on, they have a life and they are happy. They also have beautiful memories. Like my mother, she didn't have a wonderful life, but she has everything in her head and if you ask her something she has answers.

Why not me? Am I stupid? But they said that's not true. But then what? Why can't I write anymore, for example? That's a big problem. I don't want to write for other people, but for myself – I feel myself when I write.

But what should I do? What can I do? It's like my teacher said: Language is the key here in Germany. If you don't know the language, you don't have the key. For example, when I get a letter and I don't understand anything. I have to translate everything and still I don't understand it properly. I have done very stupid things because I didn't understand. I never said I didn't understand and I usually try to manage on my own. My problem is, I have read and translated a word a thousand times and then I have forgotten it again. Why does this happen? It makes me very sad - where is my voice, where has my language gone? – I miss writing.

Group discussion

Having read Amira's story, get together in an interprofessional group and have an exchange on the following questions:

1. When in your life have you ever felt that you could no longer pursue an activity, hobby or occupation or that others prevented you from pursuing it?

- What feelings did this trigger in you?
- What did you do about it?
- Who or what helped you in this situation?

2. Discuss these questions related to the situation Amira describes in her story:

- What prevents Amira from pursuing her activities and occupations?
- What feelings does she describe?
- What could Amira do about the situation?
- Who or what could be a help in the situation?

3. Share Amira's situation in relation to your specific professional focus (subject area). What concrete benefits can interprofessional cooperation bring for Amira?

4. Read the following article on occupational disruption:

Once you complete the discussion, read the article by Helen Claire Hart (2023) Imagined futures: Occupation as a means of repair following biographical disruption in the lives of refugees, Journal of Occupational Science, 30:1,24-36, DOI: 10.1080/14427591.2022.2038249

- Summarise the key messages of the text.
- What further possibilities for supporting Amira arise from the text?
- Develop a series of statements about the connection between the consequences of trauma and language learning or other important activities.

Advocacy and empowerment

Promoting the health of refugees and asylum seekers is not only a logistical challenge of making do with scarce resources, but also an ethical challenge (cf. chapter 4.3 in this module), which calls on health professionals to advocate for social justice and equity. Advocacy and empowerment are closely related concepts. Advocacy refers to efforts of advocating for the rights and needs of a particular group or individual, while empowerment refers to the process of giving individuals or groups the knowledge, skills, and resources they need to take control of their own lives and advocate for their own needs.

Health Advocacy

Health advocacy for persons with refugee experience refers to efforts to ensure that they have access to culturally and linguistically appropriate, high-quality healthcare services. This may involve advocating for policies and practices that respond to the healthcare needs of persons with refugee experience, as well as providing direct support to refugees and asylum seekers as they navigate the healthcare system. Effective advocacy requires a combination of strategies that address both the broader policy context and the needs of individual persons.

Depending on the specific target, advocacy in the context of refugee health takes place at different levels, including:

- case advocacy (for individual persons or families);
- systems advocacy (for practice changes that affect many persons with refugee experience);
- policy advocacy (for changing legislation, regulations).

Several strategies can be employed to advocate for the healthcare needs of people with refugee experience, for example:

1. Building partnerships and coalitions by working with community organizations, advocacy groups, and other stakeholders as a way to help amplify the voices of persons with refugee experience and increase the impact of individual advocacy efforts.
2. Providing information about the healthcare needs of persons with refugee experience and the challenges they face to policymakers and the public to help build support for policies and practices that address these needs.
3. Advocating for policies and practices that support the healthcare needs of persons with refugee experience, e.g. by advocating for increased funding for refugee healthcare, policies that ensure access to interpreters and other language support services, and training for healthcare providers on cultural humility and working with persons with refugee experience.

“Effective advocacy involves carefully documenting and defining the problem, targeting an ‘audience’ or group that can effect change, proposing a solution, and using evidence and data as a basis for each effort.“ (McDonald, Stymiest 2021)

The following overview taken from a guidance document on the local inclusion of migrants and refugees in support of the UN Global Compact on Safe, Orderly and Regular Migration (GCM) and the UN Global Compact for Refugees (GCR) demonstrates why advocacy is a crucial element in refugee health:

"The access of migrants and refugees to quality health services is of paramount importance to rights based health systems, global health security, health promotion, and to public efforts aimed at reducing health inequities and meeting the WHO triple billion goals, 2030 Sustainable Development Goals (SDGs): SDG Goal 3 on health, Goal 5 on gender equality, Goal 10 on reducing inequalities and Goal 16 on promote peace and end violence; all have direct implications on the health of refugees and migrants. Target 3.8 on Universal Health Coverage (UHC) provides an opportunity to promote a more coherent and integrated approach to health, beyond the treatment of specific diseases for all populations, including refugees and migrants, irrespective of their legal status. However, UHC is only a reality if health systems take account of all community members, including refugees and migrants. At the World Health Assembly in 2019, Member States agreed a five-year global action plan to promote the health of refugees and migrants. The Global Action Plan focuses on achieving universal health coverage and the highest attainable standard of health for refugees and migrants and for host populations. The Global Action Plan was fully embedded into the vision of the WHO Thirteenth General Programme of Work, 2019–2023 and its triple billion goals. In addition to the Global Action Plan, the WHO's Health in all Policies and the Healthy Cities Framework provide comprehensive approach to health, social and well-being, and equity. It puts sustainable development at the center of the local policies and programmes" (Landau et al. 2021).

Case Stories: What is the role of health advocates?

As an introduction to the topic, please watch the following video (4.45 min.) in which advocacy leader Lydia Mason from the Piedmont Community Health Center explains how she became a community health advocate:

https://vimeo.com/39174057 (= Community Health Center Advocacy)

1. What are the aims of community health center advocacy?
2. What are essential characteristics and actions of an effective community health advocate?
3. Do community health centers exist in your own country? If not, which other facilities aim to increase access to essential primary and preventative care services, in particular for people who experience restricted access to health services?

Advocacy is often written into the scope of practice of healthcare professionals. It is not something reserved for managers, professional advisers, professional associations etc. Everyone providing health services to persons with refugee experience has a responsibility to advocate for the improvement of the conditions in which care is provided. But what does advocacy mean in practice and what exactly can you do as a healthcare professional?

Claire O'Reilly is a physiotherapist working in refugee health. She has experience from various conflict zones and is particularly interested in how humanitarian health responses can be sustainable. Here, she is discussing advocacy strategies with physiotherapist and assistant professor at Trinity College in Dublin, Emer McGowan.

The interview was created in the EU-funded Physiotherapy and Refugee Education Project (PREP) that preceded the PREP IP. For more open educational resources and results from PREP please visit https://prosjekt.hvl.no/prep/prep-project/.

Listen to the interview (10 min.): https://soundcloud.com/maria-alme/emer-mcgowan-advocacy-interview?si=4d3a7dfd322f4bab807871fed425cfc5

You can find a transcript of the interview here: https://hvl.instructure.com/courses/19115/pages/Transcript%20of%20discussion%20McGowand%20and%20O%27Reilly?titleize=0

1. What type of advocacy is described?
2. Which challenges to doing health advocacy are mentioned?
3. How well can you relate to Claire O'Reilly's experience?

Now read the case story provided by Carol, an occupational therapist working in *The Pathway Homeless team* in the UK. It explains how she could support Syed to find suitable housing.

The case story was created in the EU-funded project Physiotherapy and Refugee Education Project (PREP) and is used with permission.

1. How did Carol fulfil her role as an advocate in this case story?
2. Which strategies could health professionals working for a homeless team apply at the different advocacy levels?

Case Exercises: Case Advocacy

The organization "Caring for Kids New to Canada" has published a guide for health professionals working with immigrant and refugee children and youth, which is available at: https://kidsnewtocanada.ca/beyond/advocacy#advocacy-by-health-professionals

Please read the example described under the heading "Case advocacy": "Kyi, a 3-year-old girl from Myanmar with type 1 diabetes mellitus, has just arrived in Ottawa from a refugee camp in Bangladesh with her mother and three siblings." Develop an advocacy strategy by following the steps outlined on the website and engage with the questions listed in relation to the case.

Interprofessional Exercise: Developing an Audio Play

In small interprofessional groups (3-4 persons), briefly outline a case example and then develop a short audio play (max. 5 min) based on it. Present both in the online seminar.

Your roleplay should include elements of culturally responsive practice, intercultural communication, advocacy, and empowerment.

Self-reflection exercise:

1. What are you passionate about? Is there something within the health care system in relation to refugee health that needs to be changed? Make a plan for an advocacy strategy for working towards this. Describe your idea and then write down the plan in bullet points.
2. Which rewards and challenges are associated with the role of being a health advocate for persons with refugee experience? Write down the points you find most important in a short paragraph (250 words).

You can compare your answers with those given by healthcare professionals in the following study: Stoddart, Rohanna, Simpson, Paul, Haire, Bridget. "Medical advocacy in the face of Australian immigration practices: A study of medical professionals defending the health rights of detained refugees and asylum seekers." *PLoS One*. 2020 Aug 21;15(8):e0237776. doi: 10.1371/journal.pone.0237776. Available at: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0237776

Empowerment

The concept of empowerment originated in the United States, where it became known primarily through the feminist and civil rights movements (1960s) and the self-help movement (1970s) as the ability to find one's own voice and resources. Later it became influential in the fields of social work, health policy and development cooperation as a concept representing a counterpoint to deficit-oriented, hierarchical and devaluing approaches and policies. There is a danger of assuming that empowerment is only needed by "deficient" individuals who cannot cope with their experiences alone. Instead empowerment must be understood as the right of every person who, as a result of structural disadvantage and violence, has fewer opportunities to participate equally and healthily in social life. The empowered persons are not passive recipients, but active creators of their own possibilities. Empowerment involves giving people with refugee experiences the knowledge, skills, and resources they need to take control of their own health and well-being.

Several strategies can be employed by healthcare professionals and other stakeholders to support the empowerment of persons with refugee experience in regard to health, for example:

1. Providing education and information about health and healthcare, e.g. providing information about specific health conditions, as well as general information about how to access healthcare services or what to expect during a healthcare visit;
2. Helping persons with refugee experience to navigate the healthcare system, e.g. assisting them in accessing healthcare services or connecting them with resources and services, and advocating on their behalf when necessary;
3. Advocating for policies and practices that support the healthcare needs of persons with refugee experience.

Reading exercise:

As an introduction to the relevance of empowerment in refugee health, please read the article by Azaad Kassam, Olivia Magwood and Kevin Pottie. "Fostering Refugee and Other Migrant Resilience through Empowerment, Pluralism, and Collaboration in Mental Health." It is available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7766954/

Questions:

1. How do the authors explain the need for empowerment in refugee health?
2. Which clinical interventions and settings are discussed regarding their potential to support empowerment in refugee mental health?

Empowerment in healthcare typically involves support of community-based healthcare initiatives. In refugee health, by supporting the development of initiatives that are led and controlled by persons with

refugee experience themselves, healthcare professionals can contribute to empowerment processes that will allow persons with refugee experience to take an active role in their own healthcare and the healthcare of their communities.

Reading exercise:

The article by Hyojin Im and Laura E.T. Swan "'We Learn and Teach Each Other': Interactive Training for Cross-Cultural Trauma-Informed Care in the Refugee Community" describes culturally responsive and trauma-informed mental health training modules to build and enhance competences and partnerships among different mental health professionals and refugee community leaders. It is available at: https://link.springer.com/article/10.1007/s10597-021-00899-2

Please read the following parts of the text: Introduction (pp. 917-918), Building Community and Partnership (pp. 924-925), Discussion (pp. 925-927).

What can you learn from this text about community empowerment in refugee health? Write a 250-word summary from the perspective of your own profession.

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Links

Canadian Collaboration for Immigrant and Refugee Health (CCIRH). Refugee and Elderly Global Health E-Learning. Part 4: Advocate. https://ccirhken.ca/e-learning/?page_id=416

Caring for Kids New to Canada. Advocacy for Immigrant and Refugee Health Needs. https://kidsnewtocanada.ca/beyond/advocacy#advocacy-by-health-professionals

PREP (Physiotherapy and Refugee Education Project). Interview, Emer McGowan and Claire O'Reilly, advocacy strategies, 10 min, https://soundcloud.com/maria-alme/emer-mcgowan-advocacy-interview?si=4d3a7dfd322f4bab807871fed425cfc5 Transcription of the interview https://hvl.instructure.com/courses/19115/pages/Transcript%20of%20discussion%20McGowand%20and%20O%27Reilly?titleize=0

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Module 4 Learning resources

Culturally Responsive Practice in Refugee Health

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Cross-Cultural Communication in Refugee Health

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Ethical Practice and Personal Conduct

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Module 4 learning activities and assessment

Asynchronous discussions

Module 4: Diversity in society and in health care

Module assessment

Module 4 Assignment: Interprofessional culturally-responsive practice in refugee health

Module 5: Social and Occupational Determinants of Mental Health ((UVic-UCC)

Introduction to Module 5

This module will reflect on how to improve the mental health well-being of the refugee community focusing on its social and occupational determinants. It will introduce relevant concepts, and theories. The module will go in-depth into the social determinants of mental health from the World Health Organization. This module will reflect on Post-traumatic stress disorder and Secondary stress disorder. It will also develop the occupational determinants of mental health, undertaking concepts such as occupational justice. Work and social entrepreneurship will be developed as important dimensions. The importance of work for migrants and the use of social entrepreneurship to promote employability will be highlighted. Finally, case studies will be presented during the module.

A learner who has completed the module:

- has a thorough knowledge of theories, frameworks, concepts and methods in the field of social and occupational determinants of mental health.
- can apply knowledge of the social and occupational determinants of mental health.

- can analyze and deal critically with various sources of information and use them to provide a rationale for meaningful occupational engagement of people with refugee experiences in health and social care.
- can analyze social and occupational theories, methods, and interpretations in the field of refugee health and work independently and in teams to address practical and theoretical problems.
- can advocate on behalf of clients, from the community- to policy level, to improve their access to appropriate resources and services that support their inclusion in society.

The following topics are covered in this module:

- Mental health and its social determinants.
    - Promoting mental health among refugees.
    - Post-traumatic Stress Disorder and Secondary Stress Disorder.
- Occupational determinants of mental health.
    - From social justice to occupational justice.
    - Work and migration.
    - Social Entrepreneurship for employability.

During this module learners will participate in a range of learning activities including:

- engaging with curated learning resources and asynchronous discussions
- completing the module assignment

Meet persons with refugee experiences

A Life on Hold: The story of a teenage refugee (youtube.com)

Mental health and its social determinants

Salvador Simó. UVic-UCC

Francesc Guasch. UVic-UCC

The World Health Organization (**WHO**) defines **health** as a state of complete physical, mental, and social well-being. It does not refer just to the belief that it is the absence of disease or illness (World Health Organization, 2019). The WHO also defines **mental health** as the successful performance of an individual's mental capabilities. Mental health is a state of well-being in which each person realizes their potential, can manage the changes and everyday stresses of life, can work efficiently and productively, and is capable to contribute to their community. Mental health includes emotional, psychological, and social well-being (Mao and Agyapong, 2021; p. 1) and mental health conditions include mental, neurological, and substance use disorders, suicide risk, and associated psychosocial, cognitive, and

intellectual disabilities (World Health Organization, 2019). Mental Health can be severely affecting the refugee communities, jeopardizing their health. Social determinants play a key role.

Social determinants refer to the condition in which people were born, live, and work; their gender and age; ethnic status, etc. This also includes factors such as social-economic status, educational attainment, neighborhood, and physical environment, employment, social support networks, as well as access to health care which are determined by macroeconomics, environment, and politics (Mao and Agyapong, 2021). It is important to think about the two-way relationship between poor mental health or suffering from mental health conditions and the impact it may have personal choices for example living conditions and opportunities (Alegría et al., 2018). All these aspects must be taken into account when working with forced migrants communities.

When looking at **gender** you need to think about the biological and psychological differences between men and women and acknowledge how this might impact their situations and circumstances. For example, the WHO (2002), explains that after the floods in Bangladesh, (1998) because young girls did not have access to clean water, rashes around the pelvis area and urinary tract infections were reported. Furthermore, Orui et al. (2015), conducted a follow-up study about suicide rates in tsunami disaster-stricken areas in Japan over three years. The researchers found that just after the tsunami the suicide rates were remarkably lower for men compared to national averages. However, after seven months the suicide rates increased over the national average (Mao and Agyapong, 2021; p.6). Gender is so important, during wars and migrations, girls are much more exposed to sexual abuse. Mental health needs are different depending on gender, and the services must be adapted. For example, when the first author was working with Mayan Indians he was not able to work directly with *Quetchi* women in any aspect connected to personal items. So, he needed to train a Mental Health promoter, a woman from their own community.

Age also needs to be considered. Children are considered especially vulnerable to psychological and mental health problems following disasters, especially those under eight years of age. Mao and Agyapong (2021) relate this to a child's difficulties in understanding the situation, their incapability to control the events, and their lack of ability to cope with the situation. The mental health symptoms seen in children following disasters consist mainly of anxiety disorders such as phobias, panic, or post-traumatic stress disorder (PTSD). Interestingly the studies on elderly people were the opposite; contrary to some ideas that they might be more vulnerable to disasters they found that the elderly tend to be less susceptible to depression, substance use, and PTSD after traumatic events. This could be because their knowledge and life experience has helped them to cope with difficult situations (Mao and Agyapong, 2021). Cherry et al. (2011), cited by Mao and Agyapong, (2021; p.7) explain that people in their forties and fifties are vulnerable to traumatic events due to their social and financial responsibilities. Alegría et al. (2018) explain that young adults with poor mental health or mental health conditions may see it impacting their educational performance and employment. So often, major adults are forgotten, when they are a collective with special needs, the problems and impairments associated to the adult late life interaction with the repercussion of the refugee process.

Another social determinant to consider is **ethnicity and different cultural groups**. For example, the wide range of beliefs and customs and languages spoken. Quite often ethnic minorities have lower levels of economic and social resources available to them. It is also important to consider that specific attitudes and beliefs also play a role as protective factors for mental health. Furthermore, forced migration has

been shown to hurt mental health. For example, Salami et al. (2017), cited in Alegría et al., (2018; p. 3), have shown that although migrants are generally psychologically well after their arrival, it changes over time and their mental well-being deteriorates making them more susceptible to mental health conditions. The refugee experience is very often connected to ethnic or cultural backgrounds. We cannot forget, as an example, the genocide in Rwanda, or the war in the Balkans after the explosion of Former Yugoslavia.

Social support is something to consider when related to ethnicity. Sippel et al. (2015), cited in Mao and Agyapong (2021; p.6) state that social support points out the quality and function of social relationships and takes different forms like social interactions, emotional support, instrumental or material support, information or cognitive support, etc. Mao and Agyapong (2021) go on to explain that social support can be crucially beneficial in stressful events and can help support greater resilience. Mao and Agyapong (2021, p. 8) explain that several studies (Neria et al., 2008; Norris et al., 2002; Galea., 2005) say that with a lack of social support, several psychological conditions, such as PTSD, major depressive disorder (MDD), or prolonged grief disorder (PGD) are likely to be present.

Family relationships such as parenting styles are also important factors to consider when talking about mental health. For example, having a good relationship with your family has been linked with lower depressive symptoms. Whereas people who had suffered abuse or neglect from a family member are more likely to suffer from PTSD symptoms, anxiety, or aggression. Special attention must be placed on single-parent families. We must remember that the mental health and well-being of parents and their children are directly connected, so we need to improve both to ensure a healthy family. Family reunification is a *must* with refugee communities.

This is why factors such as **social support and community belonging** are so important and impactful when looking at mental health outcomes (Alegría et al., 2018). One example of this is the study conducted by Dai et al. (2016), cited in Mao and Agyapong (2021, p. 8) that related the predictors of recovery from the disaster of the 1998 Donting Lake flood. They found that from the 321 participants who suffered from PTSD before the flood disaster, 15.89% of the survivors were suffering from PTSD 15 years later. Dai et al. (2016) found that people who were physically injured or who had lost family members and had low levels of social support were less likely to recover from PTSD. Reinforce community support is a very important Mental Health protective factor, the community can play an active role in the Mental health recovery process. For example, teachers play such an important role in the MH promotional project developed by Simó in Gjakova (Simó Algado et al, 2004a) see case study 1), or in Guatemala where teens, adults, and elders had an active role too (Simó Algado et al.,2004b, see case study 2).

Socioeconomic factors such as **unemployment and precarious employment** conditions are also associated with psychological distress (Alegría et al.,2018). Mao and Agyapong (2021, p. 8) explain that the American Psychological Association defines socioeconomic status as “the social standing or class of an individual or group” and it is measured by looking at the combination of education, income, and occupation. Alegría et al. (2018; p.2) explain that several studies in Europe and North America (Brydsten et al., 2018; Han et al., 2015; Reibling et al., 2014; Lecerof et al., 2016) have found that people low incomes are more likely to experience poor mental health and are linked with a higher risk of suffering from depression, self-harm or suicide attempts among others. Socioeconomic factors are considered one of the main factors related to psychopathological impact after, for example, natural disasters (Mao

and Agyapong, 2021). For this reason, this module will highlight aspects such as employment and social entrepreneurship, also because they are directly connected to human occupation.

Other social determinants linked to **neighborhood and community services** affect mental health too. For example, living in areas near nature or other facilities might be a protective factor for mental health, in contrast living in proximity to areas associated with violence there is a higher risk of suffering from depression, anxiety, or PTSD (Alegría et al., 2018). Several studies such as Bor et al. (2018) and Galovski (2016) cited in Alegría et al. (2018; p.3), conducted research in America where community violence was present. Both studies found a link between living near places associated with violence and negative health outcomes.

There are several **interventions** that might help to reduce the risk of negative mental health outcomes linked to social determinants, especially in areas such as housing stability, community functioning, perceived well-being, quality of life, and increased self-esteem. There are Housing First programs where homeless people are relocated to individual flats with social support services, they are given a case manager and have professionals helping them integrate back into society. These programs have shown improved housing stability, fewer hospitalizations, and more regular use of health services. Other poverty reduction programs and community-based interventions to improve neighbourhood conditions include urban planning focussed on reducing violence and substance use and promoting access to green areas. These have helped to reduce negative mental health outcomes. These are also shown to lower stress levels and increase physical activity with better overall well-being in the community. Universal primary healthcare access, community strategies, incorporating mental healthcare into social services, and community health workers have also shown mental health benefits (Alegría et al., 2018). Art and culture can play a powerful protective factor, supporting the process of the refugee to engage in host community life.

We can even relate the social determinants of mental health, with the **United Nations Sustainable Developmental Goals (SGD).** The Sustainable Development Goals are a call for action by all countries to promote prosperity while protecting the planet. They recognize that ending poverty must go hand-in-hand with strategies that build economic growth and address a range of social needs including education, health, social protection, and job opportunities while tackling climate change and environmental protection. More important than ever, the goals provide a critical framework for COVID-19 recovery (United Nations, 2023). Some of the Un SDG are equivalent to the social factors we have mentioned, as G. 5 Gender equality, or related to the economic factor (G. 1 No poverty; G 2. Zero hunger; G8. Decent work and economic growth: G 10. Reduced inequalities).

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Case study: Promoting mental health among refugees

Salvador Simó. UVic-UCC.

It is so important to promote mental health wellbeing of the refugee communities, preventing war trauma. As we have just seen, children are especially vulnerable to trauma. A preventive occupational therapy program with children surviving the Kosovo conflict is presented. The objective of the program was to facilitate the emotional expression of traumatic experiences in order to prevent the development of future psychological problems and to promote their mental health. The intervention was based on a community-centred approach with spirituality as a central focus of the intervention. The children's return from a land of war to a land of children demonstrates the potential of occupational therapy intervention in this field. With increasing awareness of populations facing social and political challenges, there is a growing importance of the concept of occupational justice and the need to work against occupational apartheid.

Article. Read the article *Occupational therapy intervention with children's survivors of war* by Salvador Simo al the *Canadian Journal of Occupational Therapy.*

Extra materials. You can see a PowerPoint from this project. Especially notice the drawings and the narratives of the children.

How can you promote mental health for refugees?

Conccetina Trimboli, Curtin University.

Here there are concrete strategies you can develop to increase refugee mental health.

1. **Raise awareness:** Educate refugees about mental health and the importance of seeking help when needed. This can be done through community outreach programs and workshops.
2. **Provide access to mental health services:** Ensure that refugees have access to mental health services, including counselling and therapy, and make sure that they know how to access these services.
3. **Offer support groups:** Set up support groups for refugees where they can connect with others who are going through similar experiences. This can help them feel less isolated and provide a sense of community.
4. **Foster a sense of belonging:** Help refugees feel welcomed and included in their new community by providing opportunities for them to participate in cultural activities, events, and celebrations.
5. Provide basic needs: Meet the basic needs of refugees, including food, shelter, and safety, as these can have a significant impact on mental health.
6. **Address trauma:** Many refugees have experienced trauma, so it is important to address this issue by providing trauma-informed care and support.
7. **Address language barriers**: Language barriers can prevent refugees from accessing mental health services, so it is important to provide interpretation services and translated materials.

8. **Foster resilience:** Promote resilience among refugees by helping them develop coping skills, such as mindfulness, meditation, and stress management techniques.

Overall, promoting mental health for refugees requires a holistic approach that addresses both the physical and psychological needs of refugees. It is important to work with refugees to understand their unique needs and challenges, and to provide tailored support and care that meets their individual needs.

Barriers that refugees may experience when attempting to access mental health services

1. **Language barriers:** Refugees may not speak the local language fluently, which can make it difficult to communicate their mental health needs and understand the services available to them.
2. **Stigma and cultural beliefs:** Mental health stigma can be prevalent in some cultures, which may discourage refugees from seeking help. Additionally, refugees may hold beliefs about mental health that differ from those of the host country, which can affect their willingness to seek services.
3. **Lack of awareness and understanding:** Refugees may not be aware of the mental health services available to them or may not understand the benefits of seeking help for mental health concerns.
4. **Lack of access:** Refugees may have limited access to mental health services due to financial constraints, transportation issues, or lack of availability of services in their area.
5. **Trauma and ongoing stressors:** Many refugees have experienced traumatic events and ongoing stressors that can affect their mental health and make it difficult to seek or engage in mental health services.
6. **Legal status and documentation:** Refugees may face barriers to accessing mental health services if they lack legal status or documentation, which can affect their eligibility for services and their ability to access healthcare in general.
7. **Cultural and linguistic competence of mental health providers:** Refugees may have unique cultural and linguistic needs that mental health providers may not be equipped to address, which can affect the quality of care they receive.

Overall, addressing these barriers requires a comprehensive approach that involves building trust and rapport with refugees, providing culturally and linguistically competent care, and addressing systemic barriers to mental health services.

International programmes running that promote the mental health of refugees.

You can contact this international programmes.

1. **The Mental Health and Psychosocial Support (MHPSS) Program:** This program is run by the United Nations High Commissioner for Refugees (UNHCR) and provides mental health and psychosocial support to refugees and asylum seekers in various countries around the world. The

program includes counselling and therapy services, community-based support, and training for mental health workers.

- Website: https://www.unhcr.org/mental-health-and-psychosocial-support.html

2. **The International Medical Corps (IMC) Mental Health and Psychosocial Support Program:** This program provides mental health and psychosocial support to refugees and other displaced populations in various countries. The program includes counselling and therapy services, community-based support, and training for mental health workers.

- Website: https://internationalmedicalcorps.org/program/mental-health-psychosocial-support/

3. **The World Health Organization (WHO) Mental Health Gap Action Programme (mhGAP):** This program is a global initiative to scale up mental health services in low- and middle-income countries. The program includes training for healthcare workers, community-based interventions, and policy development to support mental health services.

The World Health Organization (WHO) Mental Health Gap Action Programme (mhGAP):

- Website: mhGAP Mental Health Gap Action Programme (who.int)

4. **The Red Cross Red Crescent Movement:** The International Federation of Red Cross and Red Crescent Societies provides psychosocial support to refugees and asylum seekers through their Restoring Family Links program. This includes reconnecting separated families, providing psychosocial support, and promoting community-based resilience.

- Website: https://www.ifrc.org/en/what-we-do/restoring-family-links/
- Reference: International Federation of Red Cross and Red Crescent Societies (2017). Psychosocial support to refugees and migrants in Europe: A toolkit for staff and volunteers.

5. **The Center for Victims of Torture:** This organization provides mental health and psychosocial support to refugees and asylum seekers who have experienced torture or other forms of trauma. The program includes counselling and therapy services, community-based support, and training for mental health workers.

- Website: https://www.cvt.org/
- Reference: Center for Victims of Torture (2021). Healing and human rights for survivors of torture and war trauma.

Post-traumatic stress disorder and secondary traumatic stress

Salvador Simó. UVic-UCC.

Section partially based on ©Simó Algado, Salvador (2020). Interdisciplinary Cooperation in Psychosocial Interventions. A case study on refugees. Project Co-funded by Erasmus Plus Program. See http://interact-erasmus.eu/

Post-traumatic Stress Disorder (PTSD)

When we think about refugees' mental health we think about diagnoses as P**ost Traumatic Stress Disorder** (PTSD), as it is one of the most prevalent. For the American Psychiatric Association (2023) PTSD is a disorder that may occur in people who have experienced or witnessed a traumatic event or series of events. An individual may experience this as emotionally or physically harmful or life-threatening and may affect mental, physical, social, and/or spiritual well-being. Examples include natural disasters, terrorist acts, war/combat, rape/sexual assault, historical trauma, intimate partner violence and bullying.

PTSD has been known by many names, such as "combat fatigue" after World War II, but PTSD does not just happen to combat veterans. PTSD can occur in all people, of any ethnicity, nationality or culture, and at any age. PTSD affects approximately 3.5 percent of U.S. adults every year. The lifetime prevalence of PTSD in adolescents ages 13 -18 is 8%. An estimate one in 11 people will be diagnosed with PTSD in their lifetime. Women are twice as likely as men to have PTSD. Three ethnic groups – U.S. Latinos, African Americans, and Native Americans/Alaska Natives – are disproportionately affected and have higher rates of PTSD than non-Latino whites. People with PTSD have intense, disturbing thoughts and feelings related to their experience that last long after the traumatic event has ended. They may relive the event through flashbacks or nightmares; they may feel sadness, fear or anger; and they may feel detached or estranged from other people. People with PTSD may avoid situations or people that remind them of the traumatic event, and they may have strong negative reactions to something as ordinary as a loud noise or an accidental touch.

Watch the video "What is PTSD?" by the American Psychiatric Association.

https://youtu.be/uoJBvXAUvA8

A **diagnosis** of PTSD requires exposure to an upsetting traumatic event. Exposure includes directly experiencing an event, witnessing a traumatic event happening to others, or learning that a traumatic event happened to a close family member or friend. It can also occur as a result of repeated exposure to horrible details of trauma such as police officers exposed to details of child abuse cases. For **further information** about PTSD can be found on the APA webpage on PTSD.

Secondary traumatic stress

This module about Mental Health cannot neglect the therapists' one.

A personal story…

The first year I was working with Bosnian refugees I started being in contact with the traumatic memories of the refugees. It was so hard to realize and accept the degree of suffering and brutality that they had confronted.

I always will remind one day talking with Islam, an 18-year-old refugee who had been imprisoned for 6 months in different concentration camps. It was so difficult to accept that the concentration camps had returned to Europe, after the terrible existence of Auschwitz. When I read the translation of Islam's testimony, I was thinking to myself, "this cannot be possible, this cannot be possible". I knew it was. My mind did not want to accept the reality, that this is also part of human existence. I had to accept it professionally and also personally.

During that time, I listened to so many traumatic memories from several refugees, as we were working with the testimony method. Time after, I realized that my mind was creating images representing the war

and trauma scenes that the refugees were explaining to me. Although I had not really seen then, my mind was creating them.

Especially, during the second year working with the refugee community, I started experiencing feelings of hopelessness and despair. I was not the only one. One of my best colleagues was Adriano (nickname). I worked with him during the summer at the refugee camps. I had to return to Spain meanwhile he kept working during all the year at the refugee camp. When the next summer we met again, I could not recognize him. Physically my colleague was there, but his personality had changed completely. His enthusiasm and good mood had converted into apathy, negativism, pessimism and deep cynicism. He referred to me as having nightmares and difficulties concentrating. He was feeling hopeless and despair.

I realize something was going on, and I researched for scientific literature to understand it. In this way, I get to know the existence of secondary trauma on the therapist. Nobody had told me about it during my training as an occupational therapist at the university, or even when I started working with Médecins Sans Frontiers.

When working with refugees we cannot afford to ignore it, as it is a very serious condition that can be very harmful to the professionals working with people who have gone through traumatic events. It can severely affect your mental and physical wellbeing and your attitude towards life. Some years later, working in Kosovo with Médecins Sans Frontiers, a Canadian Occupational Therapist with a huge professional experience replaced me in the project to prevent war trauma among the children. I told him about secondary trauma and how to prevent it. He underestimated its potential harm. One month later, one day, he was not able to get up from the bed. He needed to be repatriated due to secondary trauma.

So, please, take it seriously.

A voice comes from the other shore and accuses me of having abandoned it.

Finkelkraut

Secondary traumatic stress (STS) is the emotional duress that results when an individual hears about the first-hand trauma experiences of another. It refers to the traumatic stress that can result from indirect exposure to an attack, disaster, or ongoing abuse. As a consequence of hearing about or seeing images of trauma, even those who didn't experience it may manifest PTSD symptoms (Newport Academy, 2019). Also known as vicarious trauma, compassion fatigue, or secondary traumatic stress disorder, is a natural but disruptive by-product of working with traumatized clients. It is a set of observable reactions to working with people who have been traumatized and mirrors the symptoms of post-traumatic stress disorder (PTSD) (Osofsky, Putnam & Lederman, 2008; Figley, 1995). STS also affects educators and caregivers.

Watch the video by Todd Grande What is secondary stress?

Understanding secondary traumatic stress

Now we will do an approximation to narratives and trauma experiences of the population of refugees and war survivors. The goal is you to have a closer understanding of the potentially traumatic impact for the professionals working with them, as they will have secondary contact with these experiences. Let me first share with you a fragment of the narrative of Islam I was mentioning at the beginning of this unit. I

warn you that its contend is very hard. Anyway, is the kind of contend you will be in contact when working with refugee communities that have gone under violence.

Islam's testimony: There is nothing they did not do to us.

My name is Islam, I am from Bugojno, since the beginning of the war I experienced difficult times. At the end of 1993 I was imprisoned at Gorni-Vakuf for five days. They interrogated me, and then took me to the Bagna-Luka concentration camp. They woke us up every morning at five and made us work until 10 or 11 at night. Then they beat us, mistreated them. I was there for a month and a half. Then they took us to Mantza. It is like a forest, in which there are old warehouses. It was cold, it was raining, or they saw nothing throwing water at us. They also came to hit us, they made scars, they put nails in our hands, they marked us with hot irons... I was there for 20 days. Then they took me to an underground where they kept me with water up to my waist, for 15 days and 15 nights tied to a scaffold. On the 16th day, when I came out, I couldn't even walk. Then the Red Cross came, they took me to a hospital in Banja-Luka. I was in the hospital for a few days and then back at the concentration camp I couldn't even walk, but it made me work. At night the guardians got drunk and in the morning some of us were missing. They disappeared at night. Then they transported us to the Sora Doboj Military Prison. There were large hangars, we had no beds, so we slept on cardboards on the floor. Again, we were beaten by both the police and the military. Some even had their fingers cut off. There is nothing they did not do us. For seven or eight days we were continually beaten. In the morning at six, we had to go to work. They made us dig trenches in the front line. We would return at 12 at night and started again the next day. During the short time we had to sleep, many times they came to beat us. There is nothing they did not do to us. While I was in Doboj, they conquered a Muslim town. They brought about 20 women, 30 children, and about 15 men. We were all in one hangar. We slept together, we could not move and it was difficult to breathe. They came just to throw us a piece of bread. We were thirsty. After a few days, women and children were taken to a neighboring hangar. We continued working. At night we heard how women were raped. There was a man who had his wife and daughter. He told us how his wife was raped and killed in front of him, and his daughter was stabbed in the stomach with a dagger. I was in Doboj until May 1994. Then we went to the prisoner exchange in Turbe. The first time, the commission to exchange prisoners did not reach an agreement. So, they put us back in prison. Then enemy soldiers came from another prisoner exchange that had turned out well. Now the soldiers who had been imprisoned by the Muslims came to beat us and revenge. There is nothing they did not do to us. Again, we took a bus and we were transferred to Travnik. We arrived at five in the morning and waited until four in the afternoon, while we were once more beaten in the bus. Finally, at four o'clock in the afternoon, the exchange of prisoners took place.

Note: Testimony recorded by the first author at T.T.S. refugee camp in October 1994. The author, Islam, gave explicit consent to share this testimony.

Now, I am sure you can understand why it was so difficult for me to accept both professionally and personally this experience, and the potential traumatic impact of these experiences for the people who work with the people who has experienced the direct trauma.

Children's survivors of war during one of the sessions. Photo by Salvador Simó.

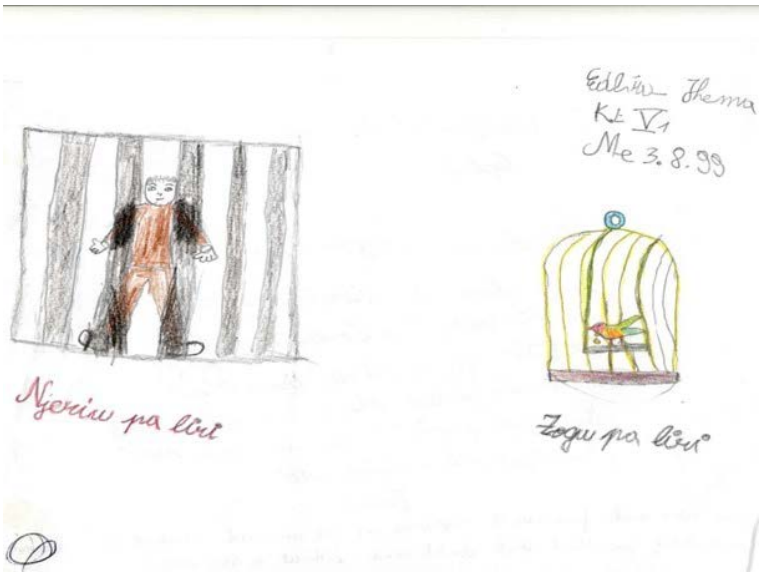
I was fortunate to work with children's survivors of war (you have already read an article about this project). The project, led by Mèdecins Sans Frontiers, was located in Gjakova, Kosovo. As our goal was to prevent emotional trauma, we were using several expressive techniques as drawings to help the children to express their experiences. The project was based on the empowerment of the teachers to conduct these sessions; and the empowerment of the children to be able to understand what was going on and the be able to manage their own emotions in a preventive level. Now we will try to understand the meaning of war thought the words and drawings from children survivors of war coming from these sessions.

"In this picture I presented crimes done by X. Killings and massacres, burning houses, shops and mosques destroyed. For this I was so worried, and in my heart, there is one big hole." Arta, 10 years.

"I have drawn the war in Kosovo. How X enemies killed people and burnt houses. They killed children, pregnant women and they made us leave. A river became of blood. My cousin was killed with 3 other girls in the basement. This is what I wanted to say about the war in Kosovo." Fjolla, 12 years.

"In this drawing I presented war which happened in Kosova. Killing, burning, massacres, massive killings, our enemies bombarding, while they burnt Albanian houses. I felt very sad, I was afraid, because when they killed Albanian, I started to cry. At 5 in the morning we went out our basement, I was afraid in my heart because I thought it was coming our turn to die." Kaltrina, 12 years.

"A mother of one Albanian soldier crying says: If I could find the body of my dead son… I would feel as he is alive, and maybe he would say to me 'mother we get what we wanted: freedom'." Saranda, 11 years.



"Although we won and the freedom is with us, we are sad because of prisoners. We are protesting for that, but until now we have had no success." Edira 11 years.

The narratives were expressing powerful narratives:

- **Sadness for the ones who are missing…**

In this theme I present Kosovo shot, because X have killed many innocent people, children and adults. This happened also to us, X killed a friend from our class. Dorina, for that I wrote a poem called: "My friend Dorina"

My friend Dorina

I remember happy days with you Our face was happy,

Now our face is sad.

Oh, that black X didn't spare you as a child, They didn't spare your sisters and brothers, but burnt you alive in the house.

In my school Teaching is started

Your empty place

It is searching for you We cover with flowers We cover with tears For the blossom

That we can never forget.

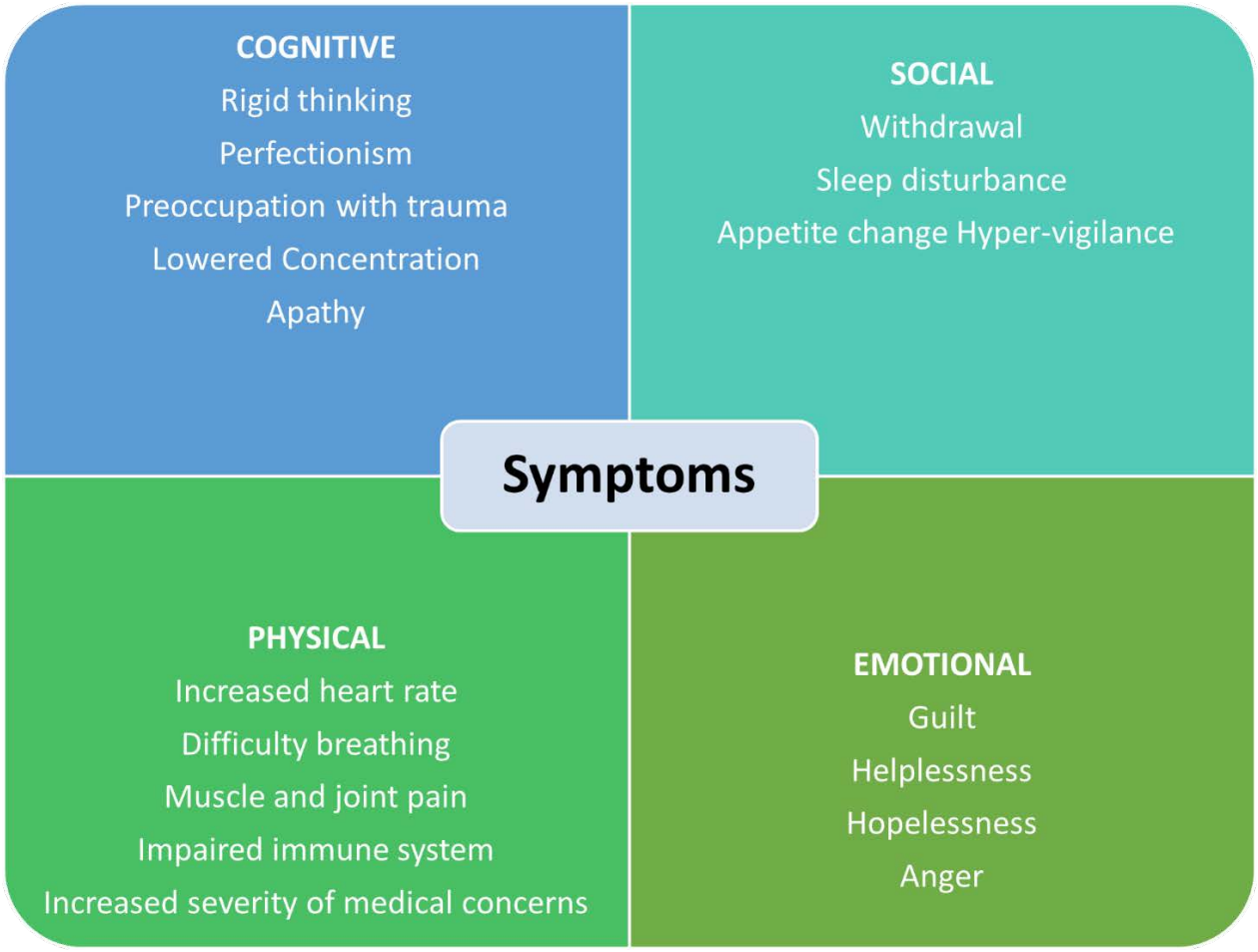
Dielleza, 11years

- **Fear of dying…**

When the war was, I was only waiting when the Serbs will enter and then they will kill us and later burn us. I always thought that would happen tomorrow, or maybe that they were going to kill one of my parents. But we were lucky. Andia, 10 years.

Symptomatology

Now that we have a closer idea of the meaning of the experiences experienced by many refugees, and the kind of histories that potentially you will listen, it can be easier to understand the **potential impact of the STS** on therapists, educators and other professionals working with the refugee community.



Newport Academy (2019) adds some more symptoms:

1. Frequent rumination on the trauma suffered by
2. Feeling inadequate and unable to help.
3. Constantly remaining on the lookout for danger.
4. Reexperiencing any personal trauma from the past.
5. Changes in perception or memory.
6. Increased anxiety and restlessness
7. Depression, anger, or numbness.
8. Fatigue and weariness.
9. Loss of trust and sense of safety.

Prevention techniques for professionals

Schema created departing for the info of The **National Child Traumatic Stress Network** (2020) and the **U.S. Department of Health & Human Services** (HHS, 2020)

My personal experience

All of us must look for the strategies more suited from him/herself. The most important is to develop a personal selfcare plan and convert them into a habit, as you must practice them with constancy. All these strategies will develop and emotional resilience that will allow us to go through this difficult professional experience without developing STS. For me, during the time I was working at the refugee camps some of the most useful strategies were:

- **Practicing sport:** To channel all the negative feelings provoked by the situation. It was very important to establish a daily sport routine. In a war context you always have serious

precautions. For example, I was not able to run on nature although I enjoy it so much due to land mine

- **Team support:** To feel you are part of a team that take cares of you, at the time you take care of them. We establish an informal supervision network. For example, when we arrived every day to the basement camp It was quite easy to detect if some of us have had a "difficult day". In that case, a walk talking about it and showing support and understanding was very important.
- **Communication:** To share the daily experiences and express the feelings of sadness, anger, frustration, hopelessness… associated with the rest of the This was one of the most powerful strategies. As they were experiencing the same reality the level of empathy was great.
- **Meditating:** To escape from the hostile present reality marked by violence and destruction to find a refugee of Personally, I always have had difficulties meditating. To meditate close to the sea listening "its voice" was a great resource.
- **Contact with nature:** To be able to enjoy the beauty of nature. Nature nurtures as. Nature is the perfect metaphor of recovery and hope: in the cold winter we keep the hope that the spring will come, after the deepest and darkest night the sunrise bights again…
- **Readings:** To read inspiring books and materials to feed the hope and nurture resilience. Personally, I love some authors, poets as Mario Benedetti or Miquel Martí I Pol that feed "my soul". I have always been inspired by leaders as Nelson Mandela or Martin Luther King. To read philosophy (Marcus Aurelius, Emmanuel Levinas, Leonardo Boff…) is another resource very
- **Artistic expression:** My expression was channelled through I always have a personal diary when travelling. There, I can express and reflect about all my experiences, feelings, emotions… It is a great activity as helps you to find meaning to the extreme circumstances you are experiencing. In fact, these diaries converted into the book *Cuaderno de viaje por la vida* (Diary of a life journey travel).

After coming back from the refugee camps:

- **Networking:** To be in contact with people who had experienced similar Normally, it is difficult that people that has not gone through similar experiences can understand you, although they are family members or close friends. Again, empathy is needed, and to share an existential (experienced) language is very helpful.

I purposely let for the end two of the most important strategies:

- **The contact with the refugee community:** To share daily moments and activities with I was able to learn from their spirit of survivors. They gave me a lesson of human resilience. The privilege to work with Indian communities taught me so much about Mayan Cosmovision, to learn that Men we are blue as we are the Heaven's heart and Women are green, as you are the Earth's heart. Also, I learn about the importance to restore our connection with nature. They believe that we born we got united with an element of nature, it can be a quetzal, a jaguar, etc. it is called your nagual and is a powerful metaphor of our dependence from Nature. In fact, all my posterior theoretical developments connected to Eco-social occupational therapy (Simó Algado & Townsend, 2015) arose from this experience.

I treasure so many moments, as every time we were travelling the elders of the community gave us their blessings or preparing the corn with Claudin at la Quetzal community in Guatemala.

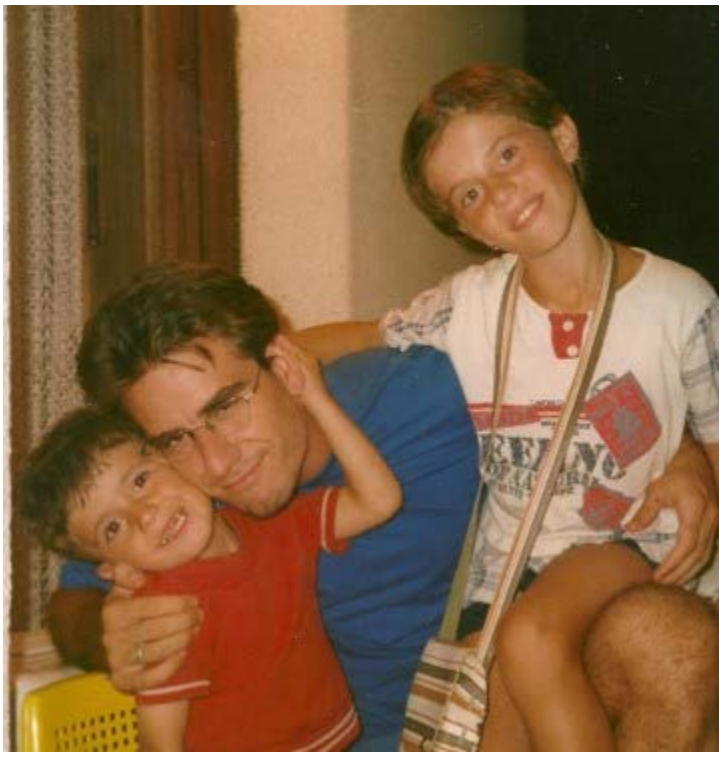


Photo: Enjoying the company of Krenora and Herden at Kosovo. Working with the children I was completely amazed by their resilience. I could not understand how after experienced such a terrible experience they were able to flourish again with the proper psychosocial support. I must say they have

been a powerful inspiration in my personal life. In moments when I was suffering due to the loss of a beloved familiar, for example, I always was remembering their testimony that has converted in a source of inspiration for me.

- **The evolution of the interventions itself.** As you can imagine is hard, professionally and personally when you listen narratives as the first ones, I presented to You will easily understand how satisfactory is when the trauma narratives turn and convert in narratives of hope and happiness. The first drawing represents the transcription you can appreciate from darkness to light.

"This symbolize freedom that people is waiting for. Pigeons symbolises freedom which already comes. Sun is the symbol of the spirit of our people; through this drawing I wanted to show the terror experienced in Kosovo. In the other side I represent a man praying God to save people of Gjakova." Besnik, 10 years.

"I draw children and flowers and big sun because sun is happy for us because we are free now." Benita, 9 years.

"I draw the beauty of future spring I was relaxed because the colours of the spring make the spirit relaxed." Durhata, 10 years

Individual Reflection

Reflect about the Secondary Stress Disorder.

- Do you think it can affect you in the future?
- Do you consider it a serious issue?
- Design a prevention plan for yourself.

Post your reflection to Module 5: Individual reflection.

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Occupational determinants of mental health

Salvador Simó. UVic-UCC

Anne Wilcock (1998) helped us to **understand health from an occupational perspective**. It generated a belief about the need for political and social change to increase occupational experiences, health, well-being, in an ecologically sustainable way, which implies the need for occupational therapists to become social activists. Examples that Wilcock reflects include ecological degradation, unemployment... so close to the situation of the refugee communities**.**

An occupational theory of the human being

This paragraph revises Wilcock's occupational theory (1998). This theory meets **Stevenson's requirements for theories** about human nature:

1. A theory about the nature of the universe.
2. A basic theory about the nature of man.
3. A diagnosis of what is the problem of man.
4. A prescription to improve his condition.

The theory is based on accepted scientific theories about the evolution of the universe and the species that inhabit it. The basic concept of the nature of human beings is **that human beings are occupational beings, because of their biological evolution and their process of enculturation.** That is, that the need to engage in occupations is part of their innate biological systems whose objective is survival and health, and that the different potential of people for different occupations is the result of their genetically inherited capacities, and of the expression and execution of the occupation is learned and modified by ecology and the sociocultural environment.

The theory proposes a simple diagnosis and its prescription: **humans have not seriously considered the repercussions of their occupational nature**, so this has affected individuals, communities and their environment, and that if we face this lack of awareness, it has the potential to produce improvements at a social, political, economic, ecological level, in people's health.

Defining health from an occupational perspective

Ideas of health vary according to cultural and spiritual philosophies, the prevailing viewpoints in society and individuals, the type of economy, and the technological resources available. As we have seen, WHO defines it as "a state of complete physical, mental and social well-being, beyond the absence of disease". Health beyond the absence of disease is a difficult thing to explain. The concept of well-being seems the key.

Defining well-being

Already Pericles in 429 BC established the connection between health and well-being. It has recently been defined as "a subjective assessment of health which is less concerned with its biological function but with feelings such as self-esteem and the feeling of belonging through social interaction". Still and everything is difficult to define. It is related to health, feeling of happiness, peace, confidence... the surveys carried out relate it to the social dimension. If we analyse well-being in relation to the mental and physical dimension:

Mental wellbeing

In this theory it includes spiritual, cognitive, and affective aspects. The American National Mental Health Association defines mentally healthy people as: “they feel comfortable with themselves… not overwhelmed by their own emotions… they can accept the disappointments of life,… experience the different human emotions such as fear, anger, jealousy, pain, love… without being incapacitated… they feel good with others …able to respond to life's challenges…accept responsibility…can plan without fearing the future, and are able to set realistic goals.

The most used texts for its definition refer to the fact that people can find meaning in their lives, interact effectively with others, reflect, solve problems, develop decision-making skills, clarify values and beliefs, manage stress, Be flexible and adapt to changes in life.

Maslow spoke of full humanity, to describe the highest degree of personal development that allows a person to recognize their potential in life and to use their strengths without selfishness. He fits into the existentialist humanist philosophy. Bumham speaks to us of the full personality, Fromm of the productive character, just as Rogers speaks of the full functionality of the person. This humanist tradition emanates from the mental hygiene movement from which occupational therapy also stems. All these approaches situate well-being in the development of the person's potential, which is also central to the health of human beings as occupational beings.

If we seek **to achieve mental well-being, occupations** must provide self-esteem, motivation, socialization, meaning, purpose, as well as sufficient intellectual challenge to stimulate neuronal physiology and foster problem-solving capacity, perception, sensory integration, attention, concentration, reflection, language, and memory. Additionally, a balance between intellectual challenge, spiritual experience, emotions, and relaxation is necessary. It is essential that the person find meaning of the highest order.

As you can imagine, these goals are difficult when working with refugee communities. Our goal is to help people to rebuild a meaningful life project. We need to go further than treating symbols, including aspects such as employment, housing, or social participation.

Social wellbeing

Many of the aspects of mental well-being include social relationships. Well-being depends entirely on the social model of health, centred on social integration, social support, and a social sense of belonging. This suggests that physical and mental well-being depend on social well-being, which results from satisfying social relationships, which depend on the ability to interact happily and effectively with people, within personal and social parameters, without fear of challenge.

From an **occupational point of view, social well-being** is achieved when the person's occupations and roles allow them to maintain and develop satisfactory social relationships with their family, relatives and within their community, and there is a balance between occupations, social participation and time. for reflection and stillness. Denying a person's ability to develop full social participation is denying their humanity. Social well-being is increased if people can develop their potential through participating in a series of socially valued occupations.

It is essential to develop programs where the refugee community can interact with the host community and to have an active participation in the community life developing meaningful occupations. It is so important to deal and combat with prejudices and social stigma.

Community and ecological well-being

The Australian Aboriginal Health Association defines it as: “The social, emotional, spiritual, and cultural well-being of the entire community. Health services should pursue the state in which all its individuals can develop their maximum potential as human beings, it implies a complete well-being of the community as a whole”. This reminds us in cultures with individualistic values that these values are recent, since the primary objective of communities was the protection of its members, and the good of the group was more important than individual survival. In societies where individual needs are more important than the needs of the community, people speak with some nostalgia of the spirit of the community. Post-industrial societies are so immersed in the material, technological and economic growth. When working with refugee communities is so important to learn about their values and establish a critical dialogue in a mutual learning process.

Holism

Considering health to include individual, community, and ecological well-being involves considering the ideas of holism. Holism comes from the Greek holos, and means complete, completeness. People are much more than a sum of cells, this encourages us to study health based on an integral vision of the person as part of a sociocultural and natural environment, supported by systems theory. The word health in English (health) derives from health and comes from hal which means complete. The top 5 characteristics of the holistic vision are:

1. Health is viewed from a positive perspective.
2. The use of natural solutions instead of technology based on highly technological solutions to maintain health.
3. Self-responsibility in health.
4. Professional responsibility focuses above all on education.

5. In emphasis on the change within health services towards aspects of behavior, the environment and society.

The characteristics of this approach are reflected in the **Ottawa Charter for Health Promotion.** This document proposed that the main actions to be developed are:

1. Construction of a public health policy.
2. Create supportive environments.
3. Strengthen community action.
4. Develop personal skills.
5. Reorient health services beyond the provision of clinical and curative services towards the broader goal of health.

The document is holistic. It recognizes the inviolable ties between people and their environment which constitutes the basis for a socioecological approach to health. Argue in favor of the conservation of natural resources in the world... promoting the reciprocal need to care for each other, our communities and our natural environment... so that the society in which one lives creates the conditions to allow the attainment of health to all its members.

The links between health and occupation are reflected. **Occupation** is the fundamental mechanism by which people realize their aspirations, satisfy their needs, cope with the environment, and getting involved in the occupation to satisfy their needs and aspirations provides the mechanism for the maintenance and growth of physical, mental, and mental capacities. and social. These are central to health. To use these mechanisms, humans must maintain or develop their physical and social environments, in which species will be able to exercise their individual and community potential. This means that individuals and communities will develop as an integral part of the ecology. This is even more important today that we assist to the emergence of environmental refuges.

Defining health from an occupational perspective

Following the perspectives of the WHO towards the promotion of health, from an occupational point of view, we can define health in this theory as:

- The absence of disease, but not necessarily disability.
- A balance between physical, mental and social well-being, obtained through significant occupations, socially and individually valued.
- Possibility of developing personal potential.
- Opportunity for social participation and cohesion.
- Social integration, support, justice, all as a part in balance with ecology.

Ecological refugees

This theory helps us to think broader. Ecological degradation has a direct impact on human health. For example, ecopsychology studies the negative health effects of ecological degradation in human psyche

and emotional well-being (Hibbard, 2003). Stanley et al. (2021) raised the alert about the development of eco-anxiety, eco-depression, and eco-anger.

Occupational dysfunction has traditionally been attributed to physical, psychosocial, and cognitive causes. Poor attention has been given to the relationship between ecological degradation and occupational dysfunction. Occupational science, psychology, and public health, among others, can contribute to these reflections. Occupational science can research the correlation between ecological degradation and its impact on self-maintenance, leisure, and occupational patterns of the individual and populations, and how it is jeopardizing access to meaningful occupations and thus creating occupational justices. Special attention needs to be devoted to the emerging field of environmental refugees, whose relocation is caused by ecological degradation that directly affects their occupational roles (productivity, self-maintenance, and leisure).

Ecological degradation is a cause of **occupational dysfunction**. The United Nations High Commission for Refugees (ACNUR, 2018) has expressed its concern for the challenges that the climate change and environmental degradation. The Institute for Economics and Peace predicted 1.2 billion **climatic refugees** by 2050 (Institute for Economics & Peace (2021). Natural disasters and environmental degradation are causing refugee displacement. Disaster displacement is one of most devastating consequences of climate change. Entire populations suffer its consequences, especially the most vulnerable communities. Environmental refugees have lost their traditional occupational patterns, due to climate change. For example, farmers who have lost their lands owing to drought or to the pollution caused by practices such as mega mining or fracking, or fishers who are struggling to survive because of the pollution of seas and oceans. They have to leave their homelands to survive and become environmental refugees. All dimensions of their occupations are affected, including productivity, self-maintenance, and leisure. They need a complete new occupational and meaningful life project.

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From social justice to occupational justice

Salvador Simó. UVic-UCC

When referring to refugees we always need to mention **Human Rights**. Human rights are rights inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status. Human rights include the right to life and liberty, freedom from slavery and torture, freedom of opinion and expression, the right to work and education, and many more. Everyone is entitled to these rights, without discrimination.

International human rights law lays down the obligations of Governments to promote and protect human rights and fundamental freedoms of individuals or groups. One of the great achievements of the United Nations is the creation of a comprehensive body of human rights law. The United Nations has defined a broad range of internationally accepted rights, including civil, cultural, economic, political and social rights. It has also established mechanisms to promote and protect these rights and to assist states in carrying out their responsibilities. The foundations of this body of law are the Charter of the United Nations and the Universal Declaration of Human Rights, adopted by the General Assembly in 1945 and 1948, respectively. Since then, the United Nations has gradually expanded human rights law to encompass specific standards for women, children, persons with disabilities, minorities and other vulnerable groups, who now possess rights that protect them from discrimination that had long been common in many societies.

See this video from United Nations about Human Rights. Link.

Human rights is a cross-cutting theme in all UN policies and programmes in the key areas of peace and security, development, humanitarian assistance, and economic and social affairs. Every UN body and specialized agency is involved to some degree in the protection of human rights. Some examples are the right to development, which is at the core of the Sustainable Development Goals; the right to food, championed by the UN Food and Agriculture Organization, labour rights, defined and protected by the International Labour Organization, gender equality, which is promulgated by UN Women, the rights of children, indigenous peoples, and disabled persons. You have all this info at United Nations about Human Rights. See this link. You have this extra resources

- Human Rights Indicators
- Universal Human Rights Index
- Human Rights Day

Human Rights are a matter of justice. Refugee communities suffer from injustice. Aristotle defined justice as “the whole of virtue” insofar as it concerns relations with others. Justice is one of the four cardinal virtues, together with prudence, fortitude, and temperance. Justice is the one that respects equality and legality, the rights of individuals, and the right of the City (State). This supposes that it is the same for all, finally that justice is fair in a legal sense and that justice is fair in a moral sense (Comte-Sponville, 2001). All theories of justice analyse some of the most common criteria of justice, to make the maxim "To each one his own" a reality. These can be ability, merit, effort, work, need... none has a universal or absolute value. The rule of justice states that equals should be treated equally, and unequal’s unequally.

One of the most meaningful political maxims cries out: "all men are (or are born) equal. This maxim does not suppose that "all men are equal in everything", but in relation to those qualities that according to the different conceptions of man and society form the essence of man, such as having dignity. Men are obviously not the same. Rousseau made the distinction of the natural inequalities of men, those produced by nature, and of social inequalities, those produced by the relations of economic, spiritual and political dominance. Thus, he intends to eliminate social inequalities, not natural ones (Bobbio, 1993). We are interested in seeing the dimensions of equality:

- **Legal equality:** “All men are equal before the law”, is universally included in all constitutions and ideologies. It is the old principle of isonomy. The main target of this assertion is the state of orders or castes in which citizens are divided into legal orders with different privileges. It is stated that all arbitrary discrimination should be excluded, understood as introduced or unjustified discrimination (and in this sense unjust).
- **Equality of rights:** it implies the enjoyment of certain constitutionally guaranteed fundamental rights by citizens. This is reflected in the Declaration of Human Rights of 1948, "men are born free and equal in dignity and " The target of legal equality, that all citizens are subjects endowed with legal capacity, is the slave society.
- **Equal opportunities:** The principle of equal opportunities places all members of a society in a position to participate in the competition of Thus, it is demanded: a) the equality of the starting points, without distinction of race, sex, social condition ... b) in understanding in which social and economic situations the rule should be applied. To place subjects who were born under unequal conditions, in equality in the starting situation, it may imply favouring the most dispossessed and disadvantage.
- **De facto equality:** It refers to equality before material goods. But what goods are we talking about? Are we also talking about spiritual or intellectual goods? The first question is what the needs worthy of are being satisfied and with respect to which it is considered worthy that human beings are equal. We can use the criterion of social utility, or the criterion of nature, which distinguishes natural needs from artificial ones. The second question is how human beings obtain and maintain the relationship with these goods. Equality will be absolute or relative, the distribution will be arithmetic or geometric, according to Aristotle "to each in equal parts" or "in proportion to ...". The most egalitarian criterion seems to be the one advocated by Marx, “to each according to his needs” (Bobbio, 1993).

Justice is the fair and equitable distribution of resources with the imperative to address those who are least advantaged. It is very important to recognize, and respect marginalized or subjugated cultures or groups, as refugees. Justice must address resources and recognition. Resources include fair distribution of social, political and symbolic as well as economic assets. Recognition and respect for all individuals and groups requires full inclusion and participation in decision making and the power to shape the institutions policies and processes that affect their lives (Adams et al. 2016). As health professionals we must specially consider the right of the refugee community to health services and to have equality of opportunities (education, housing, employment…).

Social justice is a goal and a process. The goal of social justice is full and equitable participation of people from all social identity groups that is mutually shaped to meet their needs. The process of attaining the goal of social justice should be democratic and participatory, respectful of human diversity and group differences and inclusive, affirming of human agency and capacity for working collaborative with others to create change. Forming coalitions and working collaboratively with diverse others is an essential part (Adams et al. 2007).

We can also consider **justice form an occupational perspective**. An **occupational justice** perspective focuses on “what meaningful and purposeful occupations (tasks and activities) people want to do, need to do, and can do considering their personal and situational circumstances” (Stadnyk, Townsend, &

Wilcock, 2010, p. 331). It encourages practitioners to attend to structural and power relations that can unjustly limit participation. According to Whiteford et al. (2017), occupational justice practice stretches beyond technical or instrumental goals (e.g. developing skills, improving body function, using technical supports) to address the local, national or international restrictions that limit possibilities for some populations or communities to participate.

Occupational justice is a useful concept that highlights the ethical, political, and moral dimensions of participation in occupation. It is a form of social justice that is aligned with realization-focused comparison approaches to justice instead of the mainstream emphasis on transcendental institutionalism (Sen, 2009). The concept of occupational justice may be a powerful tool to communicate the relevance of occupational therapy to social justice, and to incite practitioners to address issues of justice in traditional and non-traditional practice settings.

Wilcock suggested that **occupational deprivation** is characterized by "the influence of an external circumstance that keeps a person from acquiring, using or enjoying something" (1998, p. 145). She points to the external agencies that contribute to such deprivation including technology, division of labor and social services. Whiteford (2000: 201) defined occupational deprivation as 'a state of preclusion from engagement in occupations of necessity and/or meaning due to factors that stand outside the immediate control of the individual. That is, deprivation is the result of forces external to the person, such as other individuals; or bureaucratic, cultural, political and economic systems.

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Case study: Community intervention in Guatemala

Salvador Simó. UVic-UCC.

Section partially based on ©Simó Algado, Salvador (2020). Interdisciplinary Cooperation in Psychosocial Interventions. A case study on refugees. Project Co-funded by Erasmus Plus Program. See http://interact-erasmus.eu/

Guatemala became independent from Spain in 1821. Its political and economic system had been based on the exploitation of indigenous communities, and little changed until 1945, with the election of Juan José Arévalo and Jacabo Arbenz as presidents, in a period that became known as the "October Revolution." Cardoza and Aragón (1985) describe this period as "the beginning of ten years of spring in the country of eternal tyranny", which allowed the beginning of a union movement and agrarian reform, distributing part of the land among the poorest in the country with which they were returned to their true owners, the Mayan Indians. In 1954, a conservative coup backed by the landowners, the ecclesiastical elite, and the CIA cut off these advances and put an end to such progress and inaugurated almost half a century of military dictatorship (Woodward, 1995).

In 1960, a revolution that had the support of Cuba failed. The guerrillas fled to the mountains, from where they continued a civil war against the Army. Starting in 1962, the military intensified its campaign against the guerrillas. Between 1978 and 1983, the Guatemalan army followed a policy of “scorched earth” in the rural areas where the indigenous Mayans lived. The consequence of this was the destruction of 440 villages (Barry, 1992), with 45,000 widows and 150,000 orphans. There were 626 massacres attributable to government forces (Oficina Derechos Humanos, 1998). 200,000 Guatemalans were murdered and between half a million and one and a half million were displaced, depending on the definition of displacement adopted9. The Mayan Indians began to flee to Mexico. The United Nations High Commissioner for Refugees (UNHCR) officially recognized 46,000 refugees. It was estimated that another 150,000 Guatemalans hid in the jungles around Chiapas in Mexico (Aguacayo, 1989). The improvement in the political situation made it possible for the Mayan refugees to return to their beloved land, when a definitive peace agreement was signed in December 1996, which brought an end to 36 years of war. Those who returned are known as returnees. They returned to new communities located at the North of Guatemala, a jungle area not suited for agriculture, their principal occupation.

Guatemala it is a clear example of an extreme injustice, as equality, legality and the rights of individuals were violated. Mayan refugees did not enjoy the legal equality, isonomy. In fact, in Guatemala racism has been very prevalent in a state of orders or castes, that separates white descendants from indigenous.

Equality of rights was also violated, as the Declaration of Human Rights of 1948 was terribly injured. In fact, our first mission was to travel as “international observers” with 2 “retornos” from Mexico refugee camps to Guatemala as human shelters. The reason was that to be accompanied with international persons was giving protection to the refugee community in front of potential violation of Human Rights.

Mayan refugees were deprived form equality of opportunities. They were born under unequal conditions, without equality in the starting situation, as they had not access to good nutrition, education, health services or job opportunities, for example. They were not favored, thereby introducing positive discrimination. De facto equality was also violated as they did not enjoy equality before material goods. They were living in conditions of poverty and lack of resources at the refugee camps in Mexico. Now they go back to Guatemala, being in jungle areas, a land that it is very bad for agriculture jeopardising its present and future, in another chapter of discrimination.

So, it was so important to defend justice as the fair and equitable distribution of resources (Rawls, 1999) with the imperative to address those who are least advantaged, as the Mayan refugees. The project tried to promote resources and recognition for the community. It was very important to recognize the greatness and beauty of the Mayan culture. In fact, we spent 2 weeks in Quetzaltenango, an inner part of the country, learning about Mayan culture with an *Ajgig*, a Mayan priest, to be able to value and understand the Mayan culture and to be able to use Mayan principles to guide the project. An important part of the project was focused on social entrepreneurship trying to promote economic resources for the community, creating several projects as a vegetable garden, a textile project or vocational projects with the teenagers.

Ours first partners were the University of Zaragoza and The Jesuit Service for Refugees. It is extremely important to identify the established or natural political leaders of the communities. The most important coalition was with the political organization of the refugees, called *Comisiones Permanentes.* We contacted via The Jesuit Service for Refugees and propose to develop a common project. When this possibility was agreed with a first project proposal accepted, we travelled to Mexico where we met and work again together in the project proposal with the board of *Comisiones Permanentes*. Then we

improve it again with the board of the *Cooperativa la Quetzal*, the political organization of the community we worked with. Different parts of the project were worked together with *Ixmucané*, the women's organization and with *Maya Tikal*, the youngster's organization. It was so important to respect and empower the political structure of the community departing from their great potentiality and resources.

It is transcendental to respect the culture of the communities. We learnt about the Mayan Cosmovision with a Mayan priest, an ajigj, we spend one week learning at the inner part of the country. The Mayan Cosmovision is an articulated system of ancient symbols and meanings that represent cognitive and existential aspects of the community and of the individual. Cosmovision refers to the place and purpose of all things in the universe. It influences every human activity and involves convictions, beliefs, habits, roles and feelings. (Simó Algado, 1997). Mayan beliefs regarding the origin of illness, the role of the individual within the Universe, and the meaning of evil and suffering guided our intervention.

The case example of Guatemala shows us a case of extreme occupational deprivation. The Mayan lost their lands and traditional way of living in the agriculture sector due to the political persecution during the scorched earth campaign. As they have lost their original belongings and territories during the terrible colonization by Spaniards. During the 14 years of exile, they were not allowed to have a formal job and had to subsist from the subsidies of the government. They were deprived form their own culture. Now they return to Guatemala, although they do to bad agriculture lands where their economic future is jeopardized.

Occupational justice helps us to understand about the political economic and social factors that terribly can influence human occupational. With occupational justice as a goal, we need to ensure that the refugee community has access to meaningful occupations. To develop a transcultural safe intervention is key in this process. See the power point attached to go in deep in this occupational justice intervention.

To learn more about our concrete intervention with the Mayan refugee community, please review the slide deck**.**

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Work and migration

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This part of the module is primarily grounded in **occupational science** scholarship, in which **work** is defined as more than paid employment (Asaba, Aldrich, Gabrielsson, Ekstam, and Farias, 2020). Work encompasses a broad range of day-to-day activities, and as something situated in a socio-political landscape of conditions that afford varying degrees of possibilities for participation (Blank et al., 2015;

Shaw & Laliberte Rudman, 2009; O'Halloran et al., 2018; Veiga Seijo et al., 2017). Related concepts such as return to work, resource seeking, and (un)employment emphasize dynamic processes that include but are not restricted to only goals related to participation in the formal labour market.

Let's begin with understanding the concept of work in a broad context and acquiring tools and strategies to meet challenges relating to work and migration. Work is often associated with paid employment, which can on a first level be understood as some sort of agreement about a particular service rendered for a certain amount of remuneration. According to the OECD glossary of terms (last updated 2001), remuneration can be in the form of wages and salaries (most common) or by commission, bonuses, or in- kind payments. Moreover, an employer in a contractual agreement concerning paid employment can be i.e. a corporation, non-profit organization, or public sector organization as well as a household or a self-employed consultancy. A relevant difference between self- employment and organizational employment is that the individual remuneration should not be considered dependent on the organizations revenue in the case of an organization, as it can be in the case of self-employment.

Although work is often used synonymously with paid employment, work is conceptually broader and can include non-paid tasks or unrecognized services. For instance, household chores such as doing laundry or preparing food for other members in a family often falls under "non-paid work" (unless the services are carried out as part of a remunerated service, such as a maid service) (Primeau, 2000). Furthermore, illegal sex work generates an exchange of service for remuneration, even though this is not recognized as paid employment.

These examples are relevant because migration inherently involves moving between countries and through different legal systems. When comparing statistics about work, statistics often reflect paid employment including self-employment. Moreover, the definition of who and what to include can vary in different regions in the world. For instance, the International Labour Organization considers the working-age population those who are 15 years and older in order to favour the possibility for international comparison. Moreover, sex work can for instance be legal in some regions and thus fall under employment whereas in other regions it is illegal and thus is unrecognized. There is reason to believe that many migrants work with both recognized and non-recognized work. Caregiving types of tasks such as child rearing and caring for older family members are known to be common.

Although this can be a paid service in some countries it is not in others. These types of socio-cultural and structural phenomena are important to keep in mind when considering international comparisons and as we delve into concepts here.

Work from an occupational perspective

The following is offered as an excerpt from an article in the Journal of Occupational Science (Asaba et al 2020). Occupational therapy has had a long history in the support of occupation and work, broadly defined, and it is for this reason that an occupational perspective rooted in occupational therapy and occupational science is of relevance. At the turn of the 1900s, Harvey-Krefting (1985) wrote that, "work was not defined in terms of eventual employment, but as fulfilment of present needs" (p. 302). Work within this context encompassed leisure, although as a result of historical events the adoption of a narrower view of work as paid employment was accepted by the mid-1900s.

Toward the 1990's, a call to honour the needs of the person and reconsider emphases on work as paid employment emerged (Harvey-Krefting, 1985; Jones, 1993; Jones 1998). Jones (1998) suggested a need to break down the distinction between "work (usually 'paid employment') and activity (often involving significant physical and mental effort)" (p. 127). Broader definitions that encapsulate a wider range of occupations than traditional paid employment definitions, have emerged in occupational science and can include unpaid occupations such as domestic or household work (Cox, 1997; Primeau, 2000) and caregiving (Waring, 2017), which is also evident in other fields (Scanlan and Beltran, 2007).

The concept of intervening to support work has often been informed by an individualistic lens, however scholars are increasingly attending to the social expectations and structural conditions that hinder or prohibit people's access to work (Aldrich & Laliberte Rudman, 2016; Berr et al., 2019; Burchett & Matheson, 2010; Laliberte Rudman & Aldrich, 2016, 2017; Lintner & Elsen, 2018), in line with the broader uptake of critical perspectives in occupation- focused scholarship (Farias & Laliberte Rudman, 2016).

Recommended Readings

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Social entrepreneurship

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Life is about **storytelling**. Let's start with an amazing story from an artist and social entrepreneur called Theaster Gates, as it really shows social entrepreneurship in action and specially its potential impact. Please, go to the link: How to revive a neighbourhood with imagination art and beauty. The Center for the Advancement of Social Entrepreneurship at Duke University, defines **social entrepreneurship** (SE) as the process of recognizing and resourcefully pursuing opportunities to create social value.

Mair and Marti (2006) view **social entrepreneurship** as a process consisting of the innovative use and combination of resources to explore and exploit opportunities, that aims at catalysing social change by catering to basic human needs in a sustainable manner. Austin et al. (2006) define **social entrepreneurship** as an innovative, social value creating activity that can occur within or across the non-profit, business, or government sectors. Zahra et al. (2009) suggest that **social entrepreneurship** encompasses activities and processes undertaken to discover, define, and exploit opportunities in order to enhance social wealth by creating new ventures or managing existing organizations in an innovative manner.

Social entrepreneurs are people with innovative solutions to the most important social, health and ecological issues, as migrations. Social entrepreneurs are innovative, resourceful, and results oriented. They draw upon the best thinking in both the business and non-profit worlds to develop strategies that maximize their social impact. These entrepreneurial leaders operate in all kinds of organizations: large and small; new and old; religious and secular; non-profit, for-profit, and hybrid. These organizations comprise the "social sector."

For social entrepreneurs, the **social mission** is explicit and central. This obviously affects how social entrepreneurs perceive and assess opportunities. Mission-related impact becomes the central criterion, not wealth creation. Wealth is just a means to an end for social entrepreneurs. With business entrepreneurs, wealth creation is a way of measuring value creation. In our story, we have seen as social entrepreneurship is dealing with poverty and lack of cultural opportunities. Theaster Gates has the capacity to revive a complete neighbourhood in Chicago, and now is spreading the project to other cities.

The main **goals of social entrepreneurship** are:

- Social transformation and innovation
- Maximize social, health and ecological benefits
- Empowerment

- Transparency in the management
- Economic and ecological sustainability
- Creation of meaningful jobs

So, **why** it is extremely important SE **when working with migrant communities**? One of the concrete goals of SE is to create employment for people who have less opportunities to access to the job market. It is extremely important to remark that they must be meaningful and fair paid. As we have seen in module related to Work, it is a key dimension for migrants. People can develop themselves and contribute to host communities via meaningful jobs. If migrants do not have access to job, they are condemned to social assistance or to poverty. Host communities label them as people "just consuming social services". In a broader sense, we are creating social transformation via innovation, to maximize de social and health benefits of the migrant community. Within social entrepreneurship we are looking for a new economic paradigm, we are evolving towards one economy that bring people and communities at the centre, not the accumulation of capital as in traditional capitalism. I invite you to explore SE in deep, and economic movement a "*la décroissance sereine*" (Latouche, 2009) or the Economy of the common good (Felber, 2019).

Developing an enterprising mindset

To be social entrepreneurs we need to develop and enterprising mindset and apply it within a social mission. An **enterprising mindset** (Moon & Curtis, 2016) is the **process of identifying, developing and bringing a vision to life**, being it an innovative idea or simply a better way of doing something, in all fields of human ventures.

The **facets** of enterprising mindset are:

1. Opportunity/risk recognition, creation and evaluation
2. Creativity and innovation
3. Decision making supported by analysis and judgement
4. Implementation of ideas through leadership and negotiation
5. Taking action and reflecting on that action

The **traits** of enterprising mindset are:

1. Attitude of taking initiatives and risks
2. Visionary - clear about your goal
3. Exploring or seeking opportunities
4. Attitude of taking responsibilities
5. Ability of being persistent with an idea

The **skills** connected to enterprising mindset are:

1. Identify opportunities

2. Interpersonal, communication and networking skills
3. Critical and creative thinking
4. Resilient to pressure and challenges

The main **attitudes** are**:**

1. Hard Work - Never gives up; be persistent
2. Risk Taking - Expose yourself to failure
3. Always deliver - Take responsibility
4. Believe in yourself - otherwise who will do it?

Leadership is a key facet for SE. Leadership is the process whereby an individual influence a group of individuals to achieve a common goal. Leaders are persons that influences others; guides them and supports them in a shared goal; and points out the goal always. Depending on the situation, leaders will use one or another style of leadership. Leadership can be individual or collective. Mahatma Gandhi, Elizabeth Cady Stanton, Martin Luther King and Nelson Mandela are 4 examples of great leaders that really transformed our society and our history. Greta Thunberg is a good example of a contemporary leader.

This enterprising mindset aspects must be accompanied with a profound knowledge about the most important health, social and ecological **challenges**. One identified challenge is **how to create meaningful and fair paid jobs for the migrants** in a context were unemployment rates and normally high, and we are living a new economic crisis due to Coronavirus crisis. For example, we need to know: 1) Features of the job market in your country. 2) Specific employment rates for migrants and sectors of occupation. 3) What are the un/employment rates in the different sectors. 4) What sectors of economic activity are creating, and which ones are destroying employment. 5) What is the economic value of each activity (salaries, etc).

This reflection must be more profound as we are in the middle of the transition to a **4.0. Economy**. A 4.0. Economy is the one derived from the 4th Industrial Revolution, featured by the digitalization of the economics processes. Robotics, virtual and augmented reality, internet of the things… are taking more importance. The 4th Industrial Revolution means the destruction of millions of traditional jobs (example: supermarket cashier) and the appearance of new ones (example: 3d printer expert). Covid-19 crisis is increasing the speed of this transformation. For example, we have seen a great increase of the e-commerce in front of the traditional one during the pandemic episode. Another important reflection to be done is connected to the **ecological crisis**. We have to consider how to connect our job initiatives for migrants with the new Green Economy. Green economy is connected to reducing ecological footprint and recycling, and specially with the promotion of alternative energies. Again, this open as a new market for job creation.

Tools for social entrepreneurship

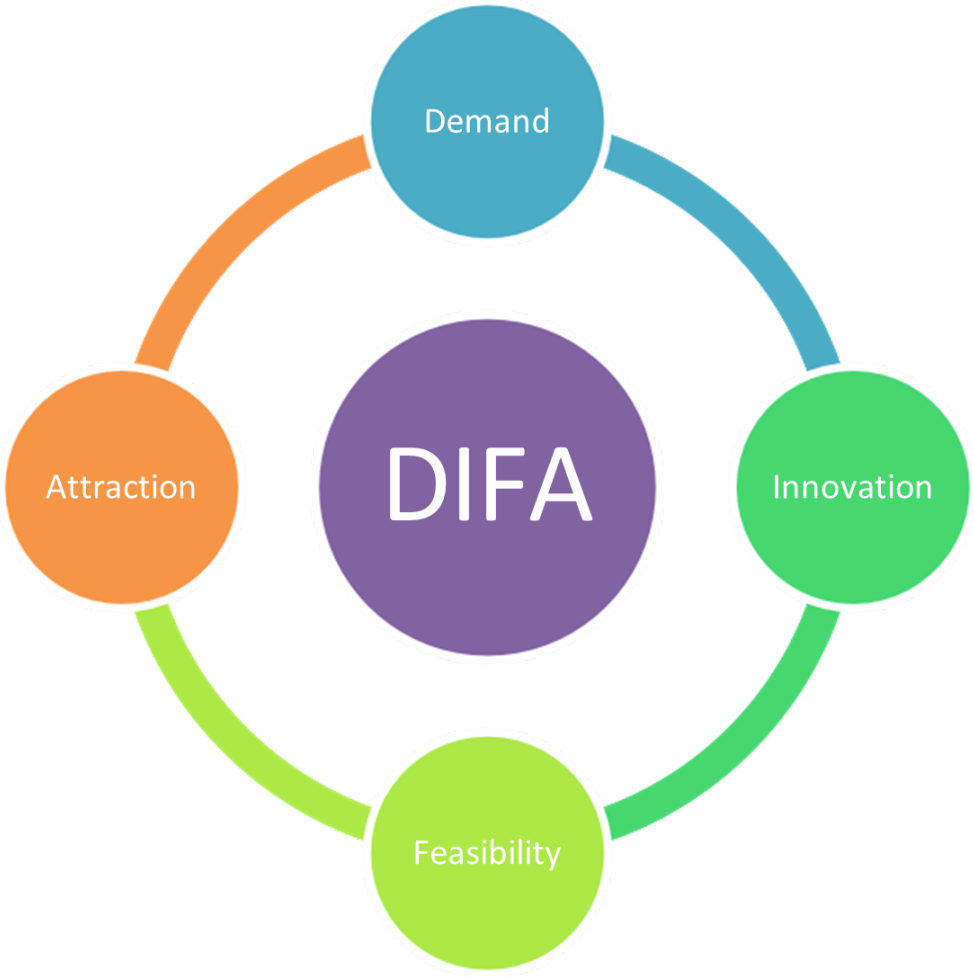
In this section we will work more in concrete and practical aspects of SE. Traditional job creation in the social field has been connected to low valued activities. This means low salaries and scarce job creation. It is so important to detect real and good opportunities. This is done normally by a team of people with

different expertise. Some models that are useful for the development of our social business ideas are presented: the DIFA Model, the Pentagon Model, the Canvas Model and the AIDA Model.

The DIFA Model

When you have an opportunity for a social business in mind, the DIFA Model allows us to analyse the opportunities we have detected, to understand its real potentiality. An opportunity, to be a good one, needs:

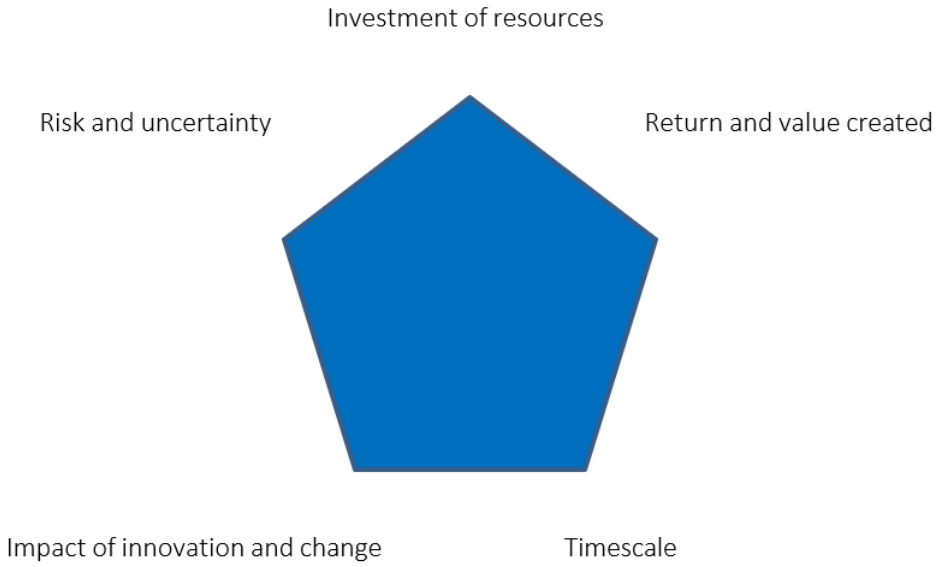
- **Demand** – actual or potential customers, need or problem, somebody who will pay for it (viability)
- **Innovation** – a product, service, process or technology can be provided, it has an added value and is innovative
- **Feasibility** – technologically feasible, resources exist and can be sourced and produced
- **Attraction** – potential reward and level of interest to the enterprising person and for the market



The Pentagon Model

Not all the opportunities we are going to detect are the proper one for us. The Pentagon Model also serves us to understand the real value of the opportunity we have detected; we can decide about their convenience reflecting about these items:

- **Investment of resources**. Does this opportunity require a huge inversion of time, capital and other resources?
- **Risk and uncertainty** and its Is it very risky to develop it?
- **Return and value created**. Is it going to create real value and benefits?
- **Impact of innovation and change** caused by the It is really innovative? Is it provoking social change?
- **Timescale**. Will we see the results soon or we have to wait too much?

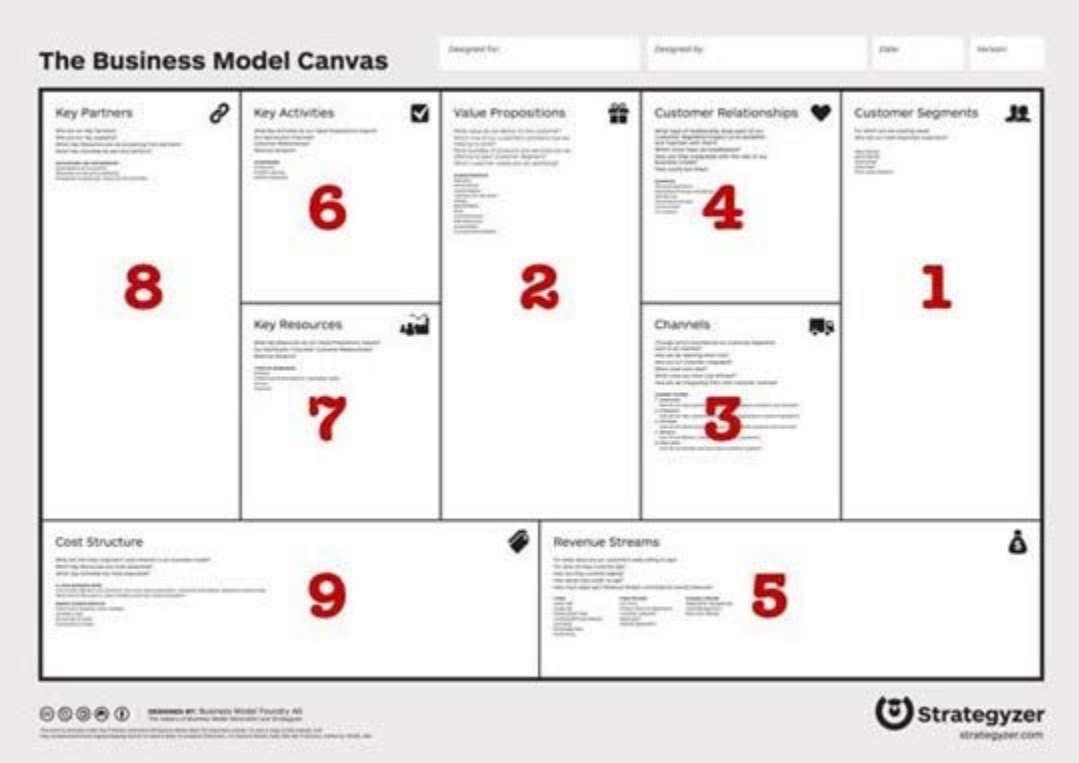


The Canvas Model

The Canvas Model help us to move from the first idea to a more complete business idea. It is based on 9 items that we have to consider when planning our social business. Please, visit the videotutorial.

1. Customer segments
2. Value proposition
3. Channels
4. Customers relationships
5. Revenue streams
6. Key activities

7. Key resources
8. Key partners
9. Cost structure



The AIDA Model

Once we have created a product or a service, the AIDA Model helps us to understand how we must work with our clients or customers. From calling their attention and making them aware of our product or service, to achieving their action (to buy or contract the services of our social business). Please, visit the **video tutorial**

Examples of social entrepreneurship initiatives

SE is not just about creating social business, although is one of their most important applications. We want to share with you some examples of SE initiates that can inspire you. All them include an important number of employers with a history of migration.

LA FAGEDA

La Fageda launched its business project in La Garrotxa in 1982 with the aim of integrating people with mental disabilities or severe mental disorders in the region into employment and socially inclusion. Currently, La Fageda is an organization with more than 300 employees. Thanks to the variety of activities it carries out (cow farm, yogurt and ice cream factory, jam maker, gardening and visitor service), it is possible to respond to all the job demands that the group of people with intellectual disability or chronic mental illness presented in La Garrotxa. Teens with difficulties are also part of the team, including migrants. At the healthcare level, La Fageda provides an Occupational Therapy Service, housing services and leisure, sports and culture services, funded by the productive activity.

La Fageda factory. © La Fageda

MOLTACTE

MOLTACTE started in 2006 with the illusion of building a new business model in which the person was the center and the motor of its development. It is focused on promoting the health of people diagnosed with mental illness. The idea was to create a healthy workplace where one could feel part of a team and reach its full potential.
MOLTACTE created a chain of fashion outlet stores through which fashion brands could kick off their stocks and where employee-to-customer relationships were a key element in reducing the stigma they often live with and increasing their own self esteem.

Moltacte shop at Llagostera. © Moltact

DONACOLORS

Dona Kolors is another social entrepreneurship project. It is a women's clothing firm that offers a job and economic opportunity to women linked to the practice of prostitution and/or a victim of sexual exploitation. Migrants are a very important part of the workers. Dona Kolors was born in 2012 and offers shelter and information services, social and health care, psychosocial care, orientation, training and job placement.

DonaKolors workshops at Barcelona. © DonaKolors.

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Case study: Social entrepreneurship – Osonament.

Salvador Simó UVic-UCC

This case is about the potential role of **social entrepreneurship** to create jobs of relevance and engage refugee communities. Social entrepreneurship is, to name a few, about meeting goals such as: 1) social transformation and innovation, 2) empowerment, 3) economic and ecological sustainability, and 4) creation of meaningful jobs.

In this case, you will learn about OSONAMENT, an illustration of social entrepreneurship, through which migrants were engaged in creating a viable café. OSONAMENT, is an illustration of social entrepreneurship developed in Catalonia, through which migrants were engaged in creating a viable and sustainable café. Through this case you will learn about:

1. The importance to have an entrepreneurial mindset always looking for new entrepreneurial opportunities.
2. To know a concrete SE project located in Catalonia related to migration and mental health.
3. How to apply a SWOT analysis, focusing on strengths and opportunities to confront weaknesses and challenges.
4. Reflect on the importance of the Art of Partnership.

We have provided you with three **videos** - these are;

1. Introduction to Social Entrepreneurship and opportunities by Salvador Simó Algado https://www.youtube.com/watch?v=nBqDZng6njw
2. The BioARTCafe by Salvador Simó Algado https://www.youtube.com/watch?v=csnrPurblQk
3. Final reflections about Social Entreprenuership and SWOT analysis by Salvador Simó Algado https://www.youtube.com/watch?v=csnrPurblQk

Module 5 learning resources

Readings

Mental Health and Its Social Determinants

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Module 5 learning activities and assessment

Discussion

- Module 5: Individual reflection on secondary stress disorder

Module Assignment

- Module 5 Assessment: Quiz