UNIVERSITY of INDIANAPOLIS®

School of Occupational Therapy

# Women's Empowerment in Refugee Resettlement

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May, 2018

A research project submitted in partial fulfillment for the requirements of the Doctor of Occupational Therapy degree from the University of Indianapolis, School of Occupational Therapy.

Under the direction of the faculty capstone advisor:

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# A Research Project Entitled

Women's Empowerment in Refugee Resettlement

Submitted to the School of Occupational Therapy at University of Indianapolis in partial fulfillment for the requirements of the Doctor of Occupational Therapy degree.

By

Jamie Guangco

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**Abstract**

Over the past two decades the global population of forcibly displaced individuals has grown to 65.6 million refugees, half being women. Refugee women experience distinct challenges in balancing traditional gender roles, identity, and expectations in a new cultural context. A solution to this is a combination of practical skills training and education that will lead to a positive resettlement transition. The purpose of this Doctoral Capstone Experience is to increase the knowledge, life skills, and self-sufficiency of refugee women through occupational engagement. The theoretical model guiding this project is the Kawa River Model, which represents how barriers in our life can impact occupational performance. Refugees in this particular capstone project experienced barriers related to English proficiency, education, life skills, and awareness of resources that prevented a positive resettlement transition to America. A needs assessment was conducted with the staff at Catholic Charities, and four six-week women's empowerment groups were completed as a result. At the end of the intervention a satisfaction survey was given. Refugee women have greater confidence in their roles as a mother, wife and woman at the end of the intervention. Refugee women valued life-skills training and women's health education to mental health information, likely due to a combination of Maslow's Hierarchy of Needs, religious beliefs, and the existence social support system. Refugees require efficient sexual and reproductive health education in order to understand contraceptive and family planning options. Overall, refugees of diverse backgrounds require different levels of occupational needs depending on their country of origin.

## Introduction

Over the past two decades the global population of forcibly displaced individuals has grown from 33.9 million in 1997 to 65.6 million in 2016, with 22.5 million being refugees (UNHCR, 2016). The term refugee was defined by the United Nations High Commissioner for Refugees in 1951 as a person "who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion". Most refugees come from urban areas and informal dwellings, with 25% coming from refugee camps. Of the 22.5 million refugees, 189,300 resettled outside of their country of origin, with the United States receiving 51% of refugees (UNHCR, 2016).

Refugees are resettled across the United States (US) through the offices of nine national resettlement agencies. Of those agencies the United States Conference of Catholic Bishops/Migration and Refugee Services (USCCB/MRS) resettles roughly 30% of US cases (USCCB). Most of their clients come from the Middle East, Africa and Southeast Asian countries, the most popular countries being Burma and Somalia. This organization emphasizes early employment for refugees as a means for self-sufficiency while also addressing their transitional needs. They offer a wide array of services including English proficiency class, cultural orientation, money management, referrals to community sources etc. However, literature suggests that despite available services in resettlement agencies, refugees continually experience decreased health and well-being.

## Literature Review

Refugees are transitioning from areas where they were displaced and had restricted occupational engagement. It is possible that newly arrived refugees experienced or still

experience effects of occupational deprivation (Suleman & Whiteford, 2013). Occupational deprivation is a state of exclusion from necessary and meaningful occupations due to external restrictions (Whiteford, 2005). Humans are occupational beings and rely on meaningful occupations for fulfillment; it is through daily occupations that individuals develop their occupational and social identity. It is important to take into account the value of an occupational perspective in addressing issues of refugee resettlement in order to facilitate successful occupational transitions for newly arrived individuals and families (Suleman & Whiteford, 2013). Occupational therapy is based upon the central idea of "achieving health, well-being, and participation in life through engagement in occupation" (Occupational Therapy Practice Framework, 2014). Occupational therapists have a unique skill set in adapting occupations and a holistic viewpoint that can help empower refugees and ease the resettlement transition. Occupation-based interventions have a role in enhancing mental health, well-being and improving confidence with unfamiliar tasks (Trimboli and Taylor, 2016).

Resettlement in a new country initially can be a relief for those escaping prosecution and war. However, once arrived confusion and fear sets in as refugees attempt to enter into a new society with a different culture from their own while still holding the physical, emotional and mental trauma from their previous life, especially for women. Approximately half of the global refugee population is women, yet they remain understudied from the perspective of gender (Shishehgar, Gholizadeh, DiGiacomo, Green, & Davidson, 2017). Refugee women face distinct challenges in balancing traditional gender roles, identity and expectations in a new cultural context (Gupta & Sullivan, 2013). Now they must adapt to their host country through reconfiguring their daily occupational lives while also attempting to be proficient in the English language. In comparison to women who voluntarily left their country of origin, refugee women

have a lower level of formal education and English language proficiency (Var, Poyrazli and Grahame, 2013). Language learning is the key to assimilating into a new culture and women typically take longer to reach a level of language proficiency as their primary caregiver role keeps them out of the workforce longer and limits opportunities for language attainment (Gupta & Sullivan, 2013). Shishegar (2016) found that the ability to communicate with others was a significant factor in securing a job, accessing education services and promoting personal autonomy. This can also hinder accessing health care services including preventive screenings such as mammography and cervical screens.

Refugees continue to participate in some of their daily occupations as they did in their home country, but many occupations were adjusted, abandoned or newly emerging (Schisler & Polatajko, 2002). Different ways of performing certain occupations in an unfamiliar cultural setting changed the meaning of these familiar roles. The reaction to occupational discontinuity is mixed, based on its impact on self-identity and life goals. Some refugee women embrace the new found roles and identities that their new host country has to offer and reached a sense of competence; others see it as a significant hardship (Gupta & Sullivan, 2013). Most women originated from countries where daily occupations such as housework and parenting were done collectively with extended family members such as Somalia and Burma, and now they felt overwhelmed doing these occupations on their own which threatened their sense of female identity and worth (Gupta & Sullivan, 2013). Refugee males now had an equal share of the homemaking tasks and parenting. Women appreciated this greater gender equality and felt a sense of freedom from tradition.

Without extended familial support, refugees experience loss of social connectedness at a community level. Work and other occupations are often used as distractions from separation

distress (Gupta & Sullivan, 2013). Having a lack of social support apart from their nuclear family can decrease rate of acculturation. A study that looked at Chechnya and Afghani refugee women found that social support significantly and consistently can reduce anxiety, depression and psychological problems over time. This can improve refugees' psychological health and acculturation process (Renner, Laireiter, & Maier, 2012). Overall most refugees desire social integration, striving to socialize with members of their host culture as well as maintaining contact with their own culture.

There is a gap in literature in regards to refugee women and sexual and reproductive health services (SRH). Studbury and Robinson 2016 found three barriers to accessing SRH services: socioeconomic status, health literacy, cultural norms and expectations and communication. Refugee women frequently lack the knowledge of SRH services and also not have had health education regarding the importance of such services (WHO, 2015). Without the knowledge of SRH services or health promotion, refugees may not seek them out or know they exist. Due to refugee's low socioeconomic status, sexual health isn't their highest priority as there are more important concerns such as housing, food and safety. In terms of cultural norms, gender roles took precedence in SRH decision making particularly family planning. Health care professionals in Australia described a patriarchal gender structure in refugee populations that gave husbands power over their spouse's sexuality and her ability to access contraception care In Arabic cultures (Mengesha, Perz, Dune and Ussher, 2017). Some refugee women have knowledge about contraception, yet they are unable to make family planning decisions because it is considered taboo and is the responsibility of the husband to make such decisions.

The solution is a combination of practical skills and knowledge that will lead to an increase in refugee confidence and ability to engage with their environment, ultimately leading to

positive occupational transitions (Suleman & Whiteford, 2013). Therefore, resettlement life skills can be considered an integral part of early transitions in refugee resettlement and a precursor to occupational engagement and well-being (Suleman & Whiteford, 2013). The World Federation of Occupational Therapists 2014 position paper on human displacement states, "…displaced people, by virtue of being human, have the right to occupational opportunities necessary to meet human needs, access human rights, and maintain health". By facilitating meaningful occupational engagement, and community integration in refugee populations the results include increased confidence and self-esteem, reduced social isolation, improved mental well-being and a renewed sense of purpose (Winlaw, 2017).

Occupational therapy can play a vital role in all aspects of adaptation and resettlement. Through purposeful and goal oriented occupations, clients are able to practice and thus master their environment. This will allow increased self-confidence, self-sufficiency and well-being of refugees. Occupational therapists can help refugees by providing opportunities to practice appropriate occupations and establish supportive relationships, facilitate expression of emotional conflicts through group work, enhance smooth transitions and adaptation in new socio-cultural environments and assist in adopting appropriate occupational roles (Kwai-Sang Yau, 1997). As occupational therapists we are rooted in mental health and social justice and should ensure that refugees are equipped with the knowledge and support they need for a positive resettlement transition.

## Purpose Statement

The purpose of this Doctoral Capstone Experience is to increase the knowledge and self-sufficiency of refugee women through occupational engagement in a six session women's empowerment group in order to create a positive resettlement transition. Each session has its

own specific goal and objects that will include life skills training and education in women's health/wellness. The refugees will be recruited through Catholic Charities Refugee Immigration in Indianapolis, Indiana. The model guiding this project is the Kawa River Model. This model is a client-centered approach used for the client to narratively draw out their day-to-day living experiences using a river metaphor (Cole & Tufano, 2008). The main purpose of the Kawa River Model is to represent how barriers in our life can impact our occupational performance. This will be used to help depict what life factors prevent refugees from experiencing a meaningful and fulfilling resettlement transition to America from their country of origin.

## Methods

The placement for this Doctoral Capstone project was the Refugee Immigration Services department of Catholic Charities in Indianapolis. A needs assessment was conducted in order to provide assistance with formulating the project's purpose and foundational goals. Three in depth semi-structured interviews were done with staff from the Refugee Immigration Services. Staff included the Director of Refugee Services, Supervisor of Resettlement Services and Manager of Vulnerable Care. Interviews with staff members were used to discuss the needs of refugees that were not being met through their resettlement services. Interviews with refugees were not conducted due to transportation constraint, language barrier and the need for multiple interpreters.

Through the needs assessment it was found that refugee women required more life skills training in daily occupations and education in women's health and rights. Life skills training topics included use of daily household appliances, managing the home, money management, hygiene, positive coping strategies and community involvement. Women's rights included reproductive rights, abuse and gender equality. Without having this knowledge, staff members

noted that, some refugee women are manipulated into marriage at an early age, unintentional oppression from the community, isolation and sex for repayment. Staff reported refugee women present with low self-esteem and self-confidence due to feeling inferior to their male counterpart and isolation from others in their community.

This is a topic that has not been explored previously and the staff at Catholic Charities wants their female refugees to gain self-sufficiency in order to not be reliant on their spouse or other male counterpart to thrive. This knowledge informed the idea to create a women's empowerment group for refugees that highlighted topics in the needs assessment using occupational therapy interventions in order to gain self-sufficiency and confidence in abilities for an overall greater occupational performance in daily life. Collaboration with refugee resettlement staff members was done to create goals for each session of the refugee women's group. A teach back method will be used to ensure that knowledge and skills were gained during each women's session. The group sessions will include life skills training as well as women's education. Suleman & Whiteford (2013) found that resettlement life skills is an integral part of early transition for refugees and is optimal for occupational engagement and well-being. By facilitating occupational engagement and community involvement in refugee resettlement, the result is great self-confidence and self-esteem, reduced isolation and a renewed sense of purpose (Winlaw, 2017).

The focus of this project is similar to working with individuals with Autism in a school-based setting; the overall goal is self-sufficiency. Occupational therapists (OT) help ease the transition to college or employment by helping students develop self-advocacy and self-determination skills in order to plan for their future (AOTA). OT services for students with special needs are determined through the Individual Education Plan (IEP) process. Working with

a school-based team they can evaluate and lead assessments to determine what is needed for a student to thrive at school. Unlike a school-based setting there is a greater emphasis on occupational deprivation and occupational justice in refugee resettlement. Giving refugees the opportunity to engage in meaningful occupation is necessary for healthy development, self-identity and community participation.

## Participants

Participants were refugee women living in Indianapolis, over the age of 15 who have been resettled by Catholic Charities. An excel sheet was gathered with a list of women who have resettled to Indianapolis within September 2016 to January 2018. Demographics of women included age, name, date of arrival, number of daughters over the age of fifteen, address, and date or resettlement. Participants were gathered using phone calls and at home in person discussion. Translation over the phone using staff at Catholic Charities was utilized when needed. Women who worked during the day were omitted. Overall roughly twenty women from varying ethnic groups agreed to participate. The women were separated based on location and ethnic group; overall four groups were assembled. This was done to ensure only one interpreter was needed for each women's group session and that group participation was within walking distance. Ethnic groups chosen were Burmese, Afghan, Syrian, and African. Grouping the women within similar ethnic groups allowed for community participation and social support.

## Implementation

The overarching theme of these groups was women's empowerment through occupational therapy based interventions. Each session contained goals based on knowledge content and life skills training. The refugee women's groups extended over a six-week period with four separate groups held each week at different apartment complexes. The groups were separated into three distinct ethnic groups; Burmese, African, Afghan and Arabic. The separation

was done to increase self-confidence, create a comfortable environment and promote social participation among the women. From these separate groups conclusions will be drawn based on needs of refugee women from specific geographical regions. Attendance and names of participants were collected prior to the start of each group. Each group was comprised of five intervention sessions and a final conclusion. Throughout the sessions during weeks one to five, the following topics were discussed: "Household Appliances and Food Safety", "Self-care and Feminine Hygiene", "Money Management", "Mental Health and Abuse", and "Women's Rights, Family Planning and Gender Equality". Material was addressed through hands-on learning, informative educational pieces and visual models. A teach back method was used to indicate if the women understood what the presenter was trying to convey. At the end of each group, an interactive questionnaire was given. The questionnaire highlighted whether the women gained any knowledge from the session and how confident they felt about teaching this content to individuals within their community. Individuals were asked to demonstrate life skills training shown in each session to gauge competence. Each group lasted one to two hours. On the sixth session a satisfaction survey was given orally due to some refugee women's inability to read or write in English. Within the group, some women had greater English language proficiency and were used as interpreters for the rest of the group. Notes were taken at the end of each group containing questions the women had during the session. At the end of the six-week intervention a presentation was given to the staff at Catholic Charities with results from the women's groups.

A women's empowerment video titled "What is a strong woman?" was created for International Women's Day on March 8. This video was used as a way to advocate for women's equality, especially for the refugee population. Women in each group were asked to participate and answer the question. "What do you think a strong woman is?". The women gave consent to

photography and video footage during the resettlement process. Their answers to the question were audio and video recorded. The occupational therapy student filmed, edited and presented the video to the Refugee and Immigration Services staff. The video was broadcasted on Catholic Charities social media page.

## Leadership Skills and Staff Development

Refugee resettlement is an emerging practice area with no occupational therapist present on site. I understood that since I didn't have a therapist on site that I would have to advocate and educate about how occupational therapy has a role in this setting. The first month at Catholic Charities involved shadowing home visits and advocating what occupational therapy is. During those home visits I noticed problem areas and discussed them with my site supervisor. Weekly sessions with the site supervisor were done in order to receive feedback; being open to change and constructive criticism of my ideas was needed for continuous improvement. Leadership skills were evident through advocating for the creation of a women's group, recruiting women, making lesson plans for each session and hosting each group. I lead each group for six weeks and made cultural sensitivity, personal attention, and empathy a priority. Based on certain ethnic group needs, I allowed feedback from the group to guide how long and how fast I discussed content.

Staff development begins with understanding what occupational therapy is and what occupational therapists can offer refugees. A presentation about occupational therapy was given to all staff members at Catholic Charities. Evidence-based literature was used to highlight OTs role in refugee resettlement. At the end of the six weeks, discussion on important topics to the women and continued areas of improvement will be presented. Staff members plan to attend the

women's groups discussed previously in order to see what issues they should address early on in resettlement.

## Discontinuation

Throughout the six-week women's groups, an informal question and answer session was asked at the end of each session that highlighted content presented. Questions were given in an open answer format in order to quantify knowledge retained and life skills gained during each session. The informal question and answer session ensures quality improvement demonstrating how well information was presented by how well the women answered each content question. Outcome measures included a percent of knowledge retained at end of session, satisfaction questionnaire, and percentage of attendance. Tables are located in the appendices at the end of this document.

Throughout all of the groups, refugee women retained the largest percentage of information regarding household appliances and feminine hygiene, while sessions regarding mental health and abuse received the smallest percentage of retention. This is partly due to the unfamiliarity to mental health and lack of an available interpreter. This data is located in Appendix B, and the questions asked during the satisfaction questionnaire can be found on Appendix D. When asked what sessions were valuable 100% voted the feminine hygiene and women's rights sessions, 75% voted the household appliances and food safety, and money management session, and 0% for the mental health and abuse session. These sessions were voted most valuable because they contributed to the women's daily activities. When asked on a scale from 1-5, with 5 being very confident, how confident are you as a mother, wife and woman after attending these group sessions, almost all women said 5 with one saying 4. An astounding 100% of women voted that they would attend group sessions if offered in the future. Women reported

that attending sessions gave them something to do with their time and looked forward to attending group each week. Most of the women were single mothers or housewives that didn't receive an education in their previous countries; attending group was an opportunity for education. Lack of education was a common theme and need for the refugee women that should be addressed.

Over twenty women in total participated in one or more women's group sessions. Specifically in the Burmese and Syrian groups, attendance changed each week, with new members invited by current members through word of mouth. Women included those who resettled through organizations other than Catholic Charities and relatives or friends of current participants. Women reported that they plan to discuss information they acquired in group sessions to others who were unable to participate. This created a dispersal of women's health and life skills information throughout the Burmese and Syrian communities of Indianapolis; therefore, expanding the amount of refugee women receiving knowledge. The African weekly group membership stayed consistent, with percentage of original group member attendance between 80 to 100% as noted in Appendix C.

The Afghan group had two members that attended consistently and one member who attended sporadically. The bilingual members in each group were used as interpreters for the non-English speaking members. Each group was given time to process the information given and relay it back to non-English speaking members of the group before continuing on. The Afghan women overall had limited English proficiency and only had one member who was bilingual; however, she attended infrequently. Due to inability to find a suitable interpreter and communicate with the women effectively, most group sessions were cancelled, rescheduled or used as English proficiency and driving safety classes. The women in this group voiced that

speaking English and learning how to drive were extremely important to them. They discussed with the OT student how the session content was useful, but what they really need is to be independent. Independence for this group was the ability to communicate with others and to drive. Eventually the Afghani women's group was disbanded due to lack of attendance and work schedule conflicts. The contents in session one and two were covered within this group.

The women's empowerment video allowed for the women to express their beliefs on what they consider a strong woman is. Across all cultures, family was the greatest emphasis voiced among all interviews. In order to be a strong woman, you must take care of your children and make sure they have everything they need to succeed. Their role as a mother took precedence over everything.

**Session Outcomes**

The Syrian and Afghan women from the Middle East were more knowledgeable of household appliances as well as food safety relative to the other women's groups. They utilized ovens in their home countries and were aware of food safety guidelines, while the women from Burma and Africa had never used an oven in their life. Specifically, women from Africa used the oven as a storage unit, placing pans full of oil and leftover food inside. Both groups lacked the knowledge of expiration dates, proper food storage and dietary restrictions during pregnancy. In session two across all groups, women were unfamiliar with feminine hygiene products such as tampons and pH balanced washes and sexual and reproductive health (SRH). As this site is affiliated with the Catholic Church and its beliefs surrounding reproduction, contraceptive information was not provided to the refugee women. Women asked questions in regards to birth control and in-vitro fertilization options, but were referred to their primary care physician for

information. The women's interest in such topics proves the need for SRH education in refugee populations.

The money management session provided training in creating a budget, writing a check and reading an electric bill. Most of the women were already familiar with most of the training presented in this session, or they reported that their husbands were in charge of finances. They were unfamiliar with creating a monthly budget, which proved to be the most valued part of this session. The ability for the women to calculate their finances and discuss ways how they can save money based on their expenses was empowering. Now they are able to save money in the future towards a college fund, house, car etc.

The women's rights session was beneficial to the refugee women because most were unaware that their rights in the United States were different than their country of origin. One woman reported that she believed her rights were identical to the ones she had previously in Ethiopia. In each group at least one woman reported that in their home country, females were seen as insubordinate to males. Over 50% of group members were married and had children by the age of seventeen, especially the women from the Middle East. All groups were encouraged to teach their children about gender equality, and discrimination. It is important that each refugee understands their civil rights, in order to not be subject to manipulation by others.

Mental health and abuse was found to be the least valuable of all the sessions and the hardest for the groups to retain knowledge. The content in this session was difficult to present due not having an interpreter present and some cultures not having a word for mental health in their dialect. To combat this issue, Catholic Charities will provide an interpreter for future women's sessions. Most of the women mentioned that physical and sexual abuse is common in their country, but were not as concerned for their safety now that they are in the United States.

The women reported they don't feel in danger or stressed because they are far away from war and are safe here in America. This creates a false belief system. They are in fact safer because they are away from war, but that may lead to issues with trusting strangers or other issues that would put them in danger of sexual or mental abuse.

Beyond the assigned group sessions, women were asked what topics they would like to learn in the future. Most women reported that they would like to be more proficient speaking English. The Burmese group reported that they would like to gain computer skills in how to buy products and pay bills online. The results of the women's sessions were presented to the staff at Catholic Charities once all groups were completed. Upon termination of services multiple pamphlets will be given to Catholic Charities to help ensure continuation of women's education. The Vulnerable Case Manager at Catholic Charities will discuss the women's group sessions with the OT student in order to learn how to present each session to continue program development. A food storage and safety checklist was developed using information gathered during the "Household Appliances and Food Safety" session. Upon resettlement a refugee's case manager must do a 24-hour visit of their apartment, to ensure safety and household appliance information is given. The checklist will serve as a guideline for food safety discussion. A sexual and reproductive health pamphlet was created for the staff at Catholic Charities to disperse amongst their mentors and volunteers in order to educate the refugee families they serve. The pamphlet highlighted women's reproductive health and natural family planning information. A mental health and abuse pamphlet was created. The pamphlet contained techniques to relieve stress and anxiety, including grounding and deep breathing methods. Signs of domestic abuse were added with hotlines to call if an abusive event occurred.

## Overall Learning

One cannot define all refugees into a singular category; each culture has its own unique customs, beliefs, and mannerisms that should be honored and explored. Humans are inherently occupational beings that derive their identity based on the occupations they pursue. Refugees are forced to navigate through a new environment with a completely new language, culture and way of life that can disrupt their occupational performance. Some refugees struggle to possess the life skills and education needed to thrive in the United States. This Doctoral Capstone Experience was implemented to empower refugee women to a positive resettlement transition through occupational engagement in a six session women's group intervention. A better understanding of refugee women's barriers to a positive resettlement transition was found.

The Kawa River Model was used as a guide to depict how barriers in refugees' lives can impact their overall occupational performance. Refugee women have barriers within their roles as a housewife, mother and woman that are created because of a new cultural context. The barriers noted throughout this doctoral capstone were English language proficiency, life skills training, lack of education, and lack of awareness to available resources. This results in occupational deprivation because refugees are unable to effectively engage with their environment due to these obstacles.

A common theme throughout the women's sessions was a drive and desire to learn English. Women invited people in their community through word of mouth in order for them to attend group sessions to practice their English proficiency skills. The Burmese and Syrian women greatly valued group sessions because they didn't work or attend school; their primary roles are a housewife and mother. Some of the women felt they weren't competent enough to hold a job due to their poor English skills; therefore group sessions were times for them to practice competence. Once English proficiency is reached, they will be able to job search and

become even more independent. The other women who didn't have a desire to work wanted to be able to communicate with doctors, cashiers, bank tellers etc. The main goal was for them to be able to interact independently within their environment. If they are unable to perform meaningful occupations, this creates lowered self-efficacy and self-confidence.

Most women voted that the money management; women's rights and feminine hygiene sessions were the most valuable. They reported that they felt more confident as a mother, wife and woman at the end of these sessions, thus increasing their self-identity and self-efficacy. Out of the sessions chosen, making a budget, understanding feminine care products, understanding food safety, and understanding their rights in the United States were discussed as the most beneficial information taught. The women valued life skills training and over mental health education. This may be due to the "Maslow Hierarchy of Needs" theory. Maslow's theory stated that people are motivated to achieve certain needs, and some needs take precedence over others. The most basic need is for physical survival and this need motivates our behavior. Once that level is fulfilled the next level up is what motivates us to act, and so on (Maslow, 1943). As refugees are struggling to accomplish the most basic needs for survival in a new country, i.e. English proficiency skills and employment, those needs take precedence over their mental health. A strong religious belief was also tied with lowered mental health concerns. In particular in the African women's group when asked if they ever feel anxious or stressed, one woman reported, "No problem, God will provide". Most women have faith in their deity to provide for them in times of trouble, as long as they have their god they will survive any circumstance. This belief can also be harmful, assuming a deity will provide can create

Throughout this experience the refugee women who participated in the women's empowerment group appeared resilient despite their life experiences. This is likely because of

the large community of refugees present in Indianapolis, especially Burmese, and Arabic speaking individuals. There are numerous mosques and Chin Baptist churches in Indianapolis that help incoming refugees acculturate to their new surroundings. Another reason could be the strong connections they have with their children and family. All of the women who participated in the women's empowerment video mentioned that prerequisite to be a strong woman was to always provide for your family.

Refugees require continued sexual and reproductive health (SRH) education. In most of the refugee women's cultures, sexuality and menstruation is considered taboo to discuss; therefore women do not seek out SRH services. Numerous questions were asked about family planning and birth control options that the occupational therapy student was unable to address due to Catholic Charities beliefs on contraceptives. All of the women who attended the feminine hygiene session were unaware of feminine hygiene products available. They reported they would use bar soap or scented soap to wash their feminine areas. Most of the women have never been to the gynecologist, or were unaware of preventative screening practices. Refugee women's lack of SRH education make them vulnerable to SRH difficulties, such as sexually transmissible infections and unplanned pregnancies in the future (Metusela et al., 2017). This knowledge should be extended to the male refugee population, so that couples can discuss family planning and other SRH issues as a unit. In contrast it is important for health care professionals to understand the socio-cultural restraints; which may inhibit SRH knowledge in refugees in order to provide culturally appropriate SRH education and services (Metusela et al., 2017).

## Implications for Occupational Therapy

Occupational therapy's unique skill set and occupational focus can bring new meaning to the lives of refugees and help counter the effects of occupational deprivation. The core belief of

occupational therapy is independence through facilitating engagement in meaningful occupations. This doctoral capstone experience supports that belief through engaging refugee women in life skills training and women's education in order to increase their self-efficacy and self-confidence in their abilities within their roles. Beyond that this project helped connect recently resettled refugee women with other more acculturated women who have experienced the same lifestyle changes. As a result a support group was created that can grow beyond this capstone experience. It is important to note as a health care provider the varying occupational needs each culture has and not to assume certain practices. As a profession we have a place within the refugee population to help enable refugees into a positive resettlement transition whether that be through facilitating new occupational roles, practicing engagement of culturally significant occupations or education.

## Appendix A

## Goals

**Session 1: Household Appliances and Food Safety**

- Clients will participate in kitchen activity in order to gain knowledge in using household appliances.
    - Appliances included: oven, dishwasher, and microwave
- Clients will be educated on food safety, and dietary restrictions during pregnancy. The group will be questioned on knowledge content presented and confidence in abilities.

**Session 2: Self-care and Feminine Hygiene**

- Clients will participate in "spa day" activities in order to build rapport with presenter and engage with other group members.
- Clients will be educated on self-care, feminine hygiene products and preventative care. The group will be questioned on knowledge content presented and confidence in abilities.
    - Products included: tampons, pads, deodorant, and feminine wash

**Session 3: Money Management**

- Clients will participate in simulated activity in order to build skills in creating a budget, filling out a check and paying bills.
- Clients will be educated on how to manage a bank account, saving for the future and reading bills. The group will be questioned on knowledge content presented and confidence in abilities.

**Session 4: Mental Health**

- Clients will participate in group activities in order to engage with other group members and discover ways to cope with stress.
- Clients will be educated on mental health, helpful coping strategies, and abuse. The group will be questioned on knowledge content presented and confidence in abilities.

**Session 5: Women's Rights, Family Planning and Gender Equality**

- Clients will be educated on women's rights, gender equality, workplace discrimination and natural family planning.
- The group will be questioned on knowledge content presented and confidence in abilities using yes or no questions.

**Session 6: Wrap Up**

- Quality improvement discussion using a Satisfaction Survey.

# Appendix B

| Percent of knowledge retained at end of session | | | | | |
|---|---|---|---|---|---|
| Group | Session 1 | Session 2 | Session 3 | Session 4 | Session 5 |
| Burmese | 80% | 60% | 75% | 75% | 60% |
| African | 80% | 60% | 60% | 50% | 50% |
| Syrian | 80% | 50% | 50% | 25% | 25% |
| Afghan | 75% | 25% | N/A | N/A | N/A |

## Appendix C

| Burmese Group | | | | | | |
|---|---|---|---|---|---|---|
| | Session 1 | Session 2 | Session 3 | Session 4 | Session 5 | Session 6 |
| Number of members attended | 6 | 4 | 3 | 5 | 3 | 4 |
| Percent of original recruitment group member attendance | 57.14% | 42.86% | 14.29% | 14.29% | 42.85% | 42.85% |
| Number of reoccurring members | 6 | 4 | 2 | 2 | 3 | 4 |
| Addition of new group members by word of mouth | 2 | 0 | 1 | 3 | 0 | 0 |

Original Recruitment Number: 7

| Ethiopian and Eritrean (African) Group | | | | | | |
|---|---|---|---|---|---|---|
| | Session 1 | Session 2 | Session 3 | Session 4 | Session 5 | Session 6 |
| Number of members attended | 4 | 4 | 5 | 3 | 4 | 3 |
| Percent of original recruitment group members attendance | 80% | 80% | 100% | 60% | 80% | 60% |
| Number of reoccurring members | 4 | 4 | 5 | 3 | 4 | 3 |
| Addition of new group members by word of mouth | 0 | 0 | 0 | 0 | 0 | 0 |

Original Recruitment Number 5

| Syrian Group | | | | | |
|---|---|---|---|---|---|
| | Session 1 & 2 | Session 3 | Session 4 | Session 5 | Session 6 |
| Number of members attended | 5 | 4 | 4 | 6 | 5 |
| Percent of original recruitment group members | 60% | 60% | 60% | 33.33% | 60% |
| Number of reoccurring members | 5 | 4 | 4 | 5 | 5 |
| Addition of new group members by word of mouth | 2 | 0 | 0 | 1 | 0 |

Original Recruitment Number: 5

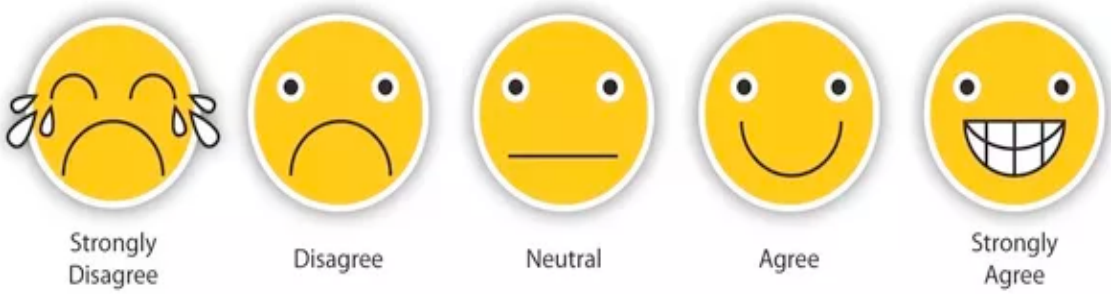
| Afghan Group | | | | | | |
|---|---|---|---|---|---|---|
| | Session 1 | Session 2 | Session 3 | Session 4 | Session 5 | Session 6 |
| Number of members attended | 3 | 2 | N/A | N/A | N/A | N/A |
| Percent of original recruitment group member attendance | 100% | 66% | N/A | N/A | N/A | N/A |
| Number of reoccurring members | 3 | 2 | N/A | N/A | N/A | N/A |
| Addition of new group members by word of mouth | 0 | 0 | N/A | N/A | N/A | N/A |

Original Recruitment Number: 3

## Appendix D

Satisfaction Survey

1. Which sessions did you enjoy the most?
2. Which sessions did you not like?
3. What else would you like to learn?
4. Were these sessions beneficial for you?
5. On a scale from 1-5, how beneficial were these sessions?
6. Why were the sessions beneficial?
7. On a scale from 1-5, how well did I teach the sessions?
8. On a scale from 1-5, how confident are you as a mother, wife and woman after attending group sessions?
9. Would you attend group sessions if offered in the future?




| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Not beneficial | Somewhat beneficial | Neutral | Beneficial | Very beneficial |
| Didn't teach well | Somewhat taught well | Neutral | Taught well | Taught very well |
| Not confident | Somewhat confident | Neutral | Confident | Very Confident |

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