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INTRODUCTION AND BACKGROUND

Refugee Trauma, Chronic Health Conditions and Health Inequities

According to the 2021 report from the United Nations High Commissioner for Refugees, 82.4 million people were forcibly displaced because of violence, wars, or persecution and over 26.4 million are currently living with refugee status (Sudhinaraset et al., 2019). Refugees are individually defined by international law as “persons outside their nationality who are unable or unwilling to return to that country because of persecution or a well-founded fear of persecution based on his or her race, religion, nationality, membership in a particular social group, or political opinion” (8 USC 1101(a) and INA 101(a)). Although the number of resettled refugees has been in decline since 2017, the United States resettled approximately 671,000 refugees (averaging 61,100/year) from 2008-2017, with many refugees from Myanmar (177,700), Iraq (144,400) and Somalia (104,100) and, more recently, since 2019, Democratic of Congo (13,000), Ukraine (4,500), Eritrea (1,800) and Afghanistan (1,200) (Krogstad 2019). With respect to health status, US-based refugees report a high prevalence of chronic diseases, with 51.1% reporting at least one chronic health condition and 9.5% reporting three or more non-communicable chronic health diseases (Yun et al., 2012). Globally, chronic diseases are associated with 70% of all deaths; however, this problem has, only recently, been acknowledged in the refugee community (The Lancet 2016).

A systematic review on the relationship between chronic pain and post-traumatic stress disorder for refugees reported a significant association of chronic musculoskeletal pain by gender, with women refugees from the Middle East and North African (MENA) countries, South Asia, Africa and Europe reporting the highest prevalence of headaches, back pain, and extremity pain (Rometsch-Ogioun et al., 2019). One study analyzed the risk factors of refugees in the United States and reported higher prevalence and risk for women with respect to obesity (46.8%), hypertension (22.6%), CAD (3.7%), diabetes (3.1%) and anemia (12.8%) (Dookeran et al., 2010). Another study of resettled South Asian Muslims reported higher prevalence and risk for women in all major chronic diseases, including diabetes. Among adult refugees, hypertension, arthritis, diabetes, chronic respiratory and cardiovascular disease are the most prevalent (Kira et al., 2012). In addition, cognitive issues related to executive function and cognitive flexibility are highly prevalent and nearly half (40-50%) of all refugees report mental health symptoms severe enough for diagnosis categories related to PTSD, depression, anxiety, somatic complaints and low self-efficacy (Nelson-Peterman et al., 2015; Pollard & Guell 2012).

Toxic stress, linked to resettlement trauma, is associated with chronic disease onset and chronic poor cognitive, mental, and physical health outcomes for refugees, including those who resettled 20-30 years ago (Pollard & Guell 2012). Refugees are 1.82 times more likely to report heart disease, 1.4 times more likely to report hypertension and 1.22 times more likely to report overall poor health conditions. Adult women refugees are an especially vulnerable sub-population within the refugee community, comprising approximately over 50% of all refugees (Wagner et al., 2013). Women report the highest

exposure to trauma, with ongoing risks for gender-based violence, poverty, unsafe space within the household and community, sex trafficking issues in transit and host countries and patriarchal privilege and power systems that reduce women's autonomy in health care decisions involving reproductive health and access to safe, acceptable quality healthcare (Sudhinaraset et al., 2019). Physical activity is one suggested rehabilitation intervention that is a cost-effective mechanism for reducing chronic disease, within the general population, and plays an important role in improving the resilience for people who have experienced toxic stress and trauma when presented in both individual and team-oriented activities (Dempsey et al., 2021; Ross-Sheriff 2013). Physical activity is an established, effective stress reliever and is associated with improved cognitive, mental, and physical wellbeing, neuroplasticity for new learning and memory, overall life satisfaction, reduced burden of pain and somatic symptoms and decreased risk for disease (Ambrose & Golightly 2015; Pedersen & Saltin 2015). Furthermore, physical activity can be easily modified to work with the local population, and implemented and monitored in community-based rehabilitation programs as part of a more complex, trauma-informed intervention program.

The purpose of this novel CBRP framework is to address health inequities among a vulnerable refugee population through program development, with a focus on: (1) active participation of the refugee community throughout all levels of program planning; (2) intersectional, gender-focused analysis of power and privilege within the community and host country aimed at reducing barriers and improving access to quality CBRP programs for women; (3) trauma-informed, team-oriented, resilience programming to improve cognitive, physical, and mental health outcomes and prevent chronic disease. This paper will also discuss the need for gender transformative interventions to address specific health inequities related to CBRP feasibility and access, cultural and social influences, acceptability, and related laws and policies and program analysis, development and implementation using physical activity as an intervention program example.

METHODOLOGY AND FRAMEWORK

Gender Analysis for a Program Intervention for Resettled Muslim Refugee Women

This paper will utilize the Jhpiego Gender Analysis Framework (GAF), affiliated with Johns Hopkins University, to contextualize one example of a community-based rehabilitation intervention, "*Physical Activity*" (PA) programs. Jhpiego GAF analyzes gender roles and relations surrounding a specific intervention and/or program and focuses the influence of power structures at micro-level (individual and household), meso-level (community and organization) and macro-level (host country laws, policies and procedures) with consideration of four domains: (1) access to assets, (2) beliefs and perceptions, (3) practices and participation, and (4) advocacy of humanitarian organizations and host countries (Penedo & Dahn 2005). The goals of the WHO Migration and Health Program target five key intersectional areas. One of these key areas is addressed by PA programs for women refugee populations that provide a means to "empowering communities for a participatory approach to health". Physical activity interventions are considered a vital part of "health promotion for improved refugee and migrant health", currently proposed by the World Health Organization (WHO) Migration and Health Program, and are the chosen intervention for this CBRP program analysis (Jhpiego 2018).

Programs combining Physical Activity (PA) and nutrition are utilized as public health interventions for refugee populations and show great success across several studies (Haith-Cooper & Waskett 2018; Pahlman 2018; Trinh et al., 2018). One such program implemented within the USA, is a PA and Nutrition Program by Mayo Clinic, in collaboration with Hawthorne Education Center (HEC), a center that services 2500 women immigrants and refugees, within the community of Rochester, Minnesota (Haith-Cooper et al., 2018). When barriers to PA are resolved, refugees appear well motivated to increase PA levels, resulting in improvements in cognitive, mental, and physical health

outcomes. Significant improvements in health and wellness of one refugee community-based health program was reported when CBRPs focused on health equity in both education and civic engagement programs (Haith-Cooper et al., 2018). Health-related quality of life (HRQoL), self-efficacy, cognitive, mental and physical health improved significantly for a group of adult women refugees who participated in a 90-minute physical activity and nutrition program, twice per week, for six weeks ($p < .001$; $p < .001$) (Trinh et al., 2018). It is important to create CBRP interventions that are culturally appropriate, trauma-informed, and gender-focused to facilitate access to rehabilitation and to increase the acceptability, availability, accessibility, availability, accommodation, and affordability for women refugees. An example of improved access to CBRP interventions is the development of a PA intervention based on culturally appropriate dance and music to address trauma-issues, while ensuring an exercise “safe space” dedicated to women only (Haith-Cooper et al., 2018).”

Trauma-informed care assumes that an individual is more likely, than not, to have a history of trauma. When community-based rehabilitation services do not use a trauma-informed approach, the possibility of triggering or exacerbating trauma symptoms and re-traumatizing individuals increases substantially. Cumulative trauma and re-traumatization may happen in any environment that resembles the original trauma or trauma environment in any form. Furthermore, re-traumatization is usually (1) unintentionally, triggered by staff, health care providers, systems or organizations, (2) exacerbates trauma related symptoms, (3) causes long-term chronic health conditions and poor cognitive, mental and physical health outcomes, and (4) reduces an individual’s willingness to engage in community-based rehabilitation interventions, thereby placing an unintended barrier to CBRP interventions (Kurtulmus et al., 2021; Malebranche et al., 2017). According to the Institute on Trauma and Trauma-Informed Care, health systems often re-traumatize vulnerable populations by requiring procedures that involve disrobing, labeling or referring to people as a “refugee” or by case number, minimizing or eliminating autonomy in health care decision making, and asking people who are resettling to a host country to continually tell and re-tell their story. Relationship re-traumatization is based on power, control and subversiveness (often of community-based health care providers and/or staff) where women who are resettled in a host country report “not being seen or heard”, frequent trust violations with the staff or providers, failure to provide and ensure an emotional “safe-space”, non-collaborative care, providers who do things “for” rather than “with” people and the use of punitive treatment (i.e. missed appointments resulting in discharge from program, etc.), coercive practices (i.e. only having a male provider available for women refugees), and oppressive language by health care providers and staff.

Any trauma-informed PA intervention for a refugee community must be analyzed and assessed as part of a holistic CBRP framework that examines the gender-based barriers and facilitators to PA interventions for both men and women, within both the country of origin and the host country. Key barriers to CBRP have been identified and include issues such as migration, lack of autonomy, lack of necessities including food and equipment, poor knowledge of the area upon resettlement, weather, and lack of time and child-care resources. Other gender-based barriers include issues related to power and privilege in the household, community, health systems, and laws and policies in the host country that prohibit women from participating in safe, effective, and sustainable PA interventions.

Key facilitators to accessing CBRP PA interventions involve stress reduction, feelings of security and settlement, exercising with family and friends (community), and understanding the impact on physical health outcomes as they relate to chronic health and disease (Trinh et al., 2018). Men in some Muslim communities are the educators and gate-keepers for women’s access to CBRP and in others they may be the facilitators for community CBRP interventions. Therefore, it is equally imperative to understand the barriers and facilitators to PA interventions for men in the community to improve access to CBRP PA interventions for women refugees. Barriers to PA for the male refugee community include:

(1) Limited time for physical activity because of the primary time priority devoted to employment as a means to support family in the host country and abroad, (2) cost of the PA intervention, (3) embarrassment of wearing exercise clothes, (4) fear of harassment, (5) change of environment from home country, and (6) prohibitive winter weather (Wieland et al., 2012). In contrast, the facilitators for PA included: (1) knowledge about the benefits of PA, (2) belief in the importance of PA as part of a lifestyle change, (3) success stories of other Muslim men as motivational, and (4) supportive structural and community cohesion with obligatory daily prayers for men held at the local *Masjeds* (Mohamed et al., 2013).

PA and cross-disciplinary collaborative interventions report significant improvements in cognitive, physical, and mental health, self-awareness and self-confidence, and reduction of daily stressors and significant relief and recovery from trauma (Nilsson et al., 2008). A group setting and team-based activity for PA interventions also assist with overcoming social fear and isolation, improve family life and social relationships, and improve conflict resolution skills related to trauma. Lack of available, culturally appropriate dress for women's swim attire and workout/gym clothing and lack of "women only safe spaces" can also be a primary limitation and barrier to physical activity participation for women (Abdulwasi et al., 2018). These barriers highlight the need for the cultural and gender-focused adaptation for physical activity interventions with an assessment of sport attire, self-efficacy beliefs regarding participation in PA interventions, processes for participation that are gender-focused and provide "safe spaces" as part of analysis of the setting and surroundings, and norms within the community regarding gender and educational tools that are culturally acceptable and provide the highest possible access to the CBRP intervention. Further facilitators for Muslim women refugees include programs that provided a social context for physical activity, variable/flexible time scheduling, shorter bursts of physical activity, and provision of a safe space for physical activity (Abdulwasi et al., 2018; Robinson et al., 2019).

DOMAIN 1: ACCESS TO ASSETS

Access to assets may be considered in relationship to the domains defined by Jhpiego's Gender Analysis Framework (GAF) (Penedo & Dahn 2005). Access to assets is the first domain of Jhpiego's GAF and must include access to transportation, child-care, and time away from home management activities to be able to engage in lengthy CBRP interventions. Provision of child-care, language interpretation, transportation, and "women only spaces" are listed as primary needs by Muslim women refugees across the research. For Muslim men, access to assets include peer to peer support, cohesion and collaboration within the community and centered around religious participation and obligatory prayer times (Haith-Cooper et al., 2018; Wieland et al., 2012). The focus on child-care as an issue centered for women-only, suggests a gap in autonomy for refugee women and a dependence upon male decision making that may only worsen in a host country, such as the USA, where child care costs may be prohibitive and only sparse social support exists for child-care programs. For many refugees, the sole responsibility for child-rearing and household management is entirely upon the woman in the family, which becomes the major barrier for accessing any community-based rehabilitation program (Calzda 2010; Kelly et al., 2019). Furthermore, Muslim women who are newly resettled refugees do not have the traditional home country social setting that allows for "women only spaces" and they are bereft of the normal "social capital" of extended family members who could assist them in taking part in the supervision and care of the children. Physical activity may also employ limited opportunities for women to walk outside of the household because of the lack of transportation, poor access to monetary funds, safety issues and limited knowledge of the language and local region (Haith-Cooper et al., 2018).

DOMAIN 2: BELIEFS AND PERCEPTIONS

The second GAF domain, “beliefs and perceptions”, is concerned with how women and men should behave within the refugee community, and significantly varies among community members. However, despite very heterogeneous beliefs and perceptions in the Muslim community, there remains significant evidence from the literature that indicates agreement from a majority of refugee Muslim women that prioritizes a “space that is for women only, without any male presence or interference (Haith-Cooper et al., 2018).” Muslim men from the refugee community, however, do not list this as a primary concern and, instead, report “fear of embarrassment” as the greatest barrier to participation in a PA program. With respect to motivational beliefs and perceptions, intra-family pressure on Muslim women is deemed more important for improving PA participation in PA programs. In contrast, peer to peer, male participation from the same community is the single greatest priority for improving participation and predictor of long-term sustainability in PA interventions.

Gender-appropriate provider selection and autonomy is crucial to the success of any CBRP intervention. Some Muslim women report a preference for a woman health care provider during discussions about their health, while others may choose according to the specialty area of the health care provider and not by gender (Scuglik & Alarcon 2005). Male physicians reported “difficulty communicating” with Muslim female patients during a medical visit that also interfered with compliance to the overall health program because of the cultural traditions and religious beliefs of some Muslim women who expected and preferred a female health care provider (Calzda 2010). Self-efficacy and autonomy regarding health care decision making is not emphasized as a strong theme for refugee women throughout the literature, but warrants further investigation to explore autonomous health care decision making in a safe individual space and open dialogue with refugee women (Haith-Cooper et al., 2018). In some Muslim refugee families, health care decisions for women, including access to CBRPs, are controlled by other family members (father, husband, brother, son, mother-in-law) within the household and may directly impact access to CBRP and PA interventions.

In some subcultures, within the Muslim refugee community, PA in mixed gender public venues may also be prohibited, thereby reducing availability for implementation of PA interventions for refugee women living in that community (Degni et al., 2012). Some Muslim communities prohibit a woman from leaving the house without explicit permission from her husband and/or “mahram” (son who is 12 or older, father, or brother). This, in turn, may create either a barrier to the implementation of CBRP interventions, by reducing direct access for women. In contrast, within the GAF framework, this may provide an opportunity to promote CBRP interventions to all members of the refugee community, including those who hold power and privilege within the refugee community, as a means to gain support for and trust of the community and to facilitate access to women’s CBRP interventions.

In the development of CBRP interventions, particularly for programs that involve trauma-survivors or sensitive health information and group participation, privacy cautions must be considered when information provided in group settings has the potential to be used by other group members to cause social or other harm to the individual participants. If approached in a culturally sensitive way, older women in the refugee community may be considered facilitators for younger women’s participation and improve access to CBRP interventions. Without careful consideration of these key positions of power and privilege within the community, many women refugees may be unable to participate in even the best planned CBRP program. It is crucial to address the program development and implementation with key stakeholders of power and privilege, within the household and community, to facilitate access to CBRP interventions for most Muslim women refugees.

DOMAIN 3: PRACTICES AND PARTICIPATION

The third GAF domain, “practices and participation”, should also be considered as CBRP interventions are implemented (Ambrose & Golightly 2015). Roles and responsibilities for women living in refugee communities are shifted during the resettlement process, particularly noting that 60-80% of all refugee women have one or more children (Devlin et al., 2012). Many women, who traditionally rely upon male family members for income, including a husband, son, or extended family member, upon resettlement may be, suddenly, responsible for both household income and complete household management, once they are resettled in the host country. This doubles the burden for women refugees living in the USA and reduces the acceptability of a CBRP program that doesn’t address time, household burden, transportation and child-care as part of a holistic effort to address health inequities among newly resettled women refugees. Consideration should be given to important factors that may directly impact the practices and participation of women following resettlement, including child-care, transportation costs, monetary or other valuable incentives for participation, and flexible scheduling of programs to accommodate the diverse and busy schedules of refugee women for implementation of any CBRP intervention. For cultural and gender-sensitive program planning of transportation needs of Muslim refugee women, consideration should be given to preference for women drivers, women health care providers, and other privacy restrictions necessary to ensure the reputation of the woman to and from the CBRP program for all program development to improve participation in community-driven programs.

DOMAIN 4: INSTITUTIONS, LAWS, AND POLICIES

Finally, the fourth GAF domain of institutions, laws, and policies may impact development and implementation of CBRP programs (Penedo & Dahn 2005). Refugee women and men who identify as racial or ethnic minorities, may suffer even greater systemic microaggressions and bias from health care systems within the host country that creates another level of power and privilege pivoted against an already vulnerable population (Lazar et al., 2013; Refugee Statistics 2021; Simpson & Carter 2008; White et al., 2015). Some Muslim women refugees are especially vulnerable to provider bias and microaggressions toward certain cultural dress in public spaces. Hijab, niqab, and/or abayas and other cultural and religious dress is essentially connected to the identity and respect of a Muslim woman within the Muslim community and, unfortunately, is directly linked to discriminatory health practices and inequitable privilege status within Western host countries (Alcade et al., 2020; Lu & Chen 2004; Padela & Zaidi 2018; Weischselbaumer 2019). To reduce this bias, community-based and other health providers should prioritize training to reduce microaggressions and implicit bias and improve cultural humility and sensitivity training for all people involved in planning and assessment of the CBRP and interventions. An explicit plan on how to mitigate these issues and provide the best care for Muslim women refugees should be developed involving local partners within the refugee community. Ultimately, this will improve communication between community provider and women refugees and contribute positively to improving health equity for refugee women.

Based on the above evidence, future CBRP programs must extend beyond the current culture and gender-blind model and begin to address some of the intersectional issues related to gender-based health inequities faced by refugee women in both research and practice models. While some of the current CBRP programs acknowledge some gender norms, they fail to address the gender inequities and do not provide CBRP development with a lens specific to the intersectional cultural needs of Muslim women refugees. Moreover, CBRPs must begin to address the underlying systems of inequitable power distribution within refugee individuals and households and the power and privilege in health systems, laws and policies that perpetuate microaggressions and bias against Muslim refugee women and reduce access to quality CBRP and interventions to an already vulnerable population.

DISCUSSION

Recommendations for a Trauma-informed, Gender-Focused, Intersectional Approach to Community-Based Rehabilitation Program for Muslim Women Refugees

Short Term Recommendations:

- Focus publicity and education regarding CBRP interventions on refugee women, adolescents who may be in charge of decision making for sisters or mothers, older women and men who are family members or part of the community power system.
- Employ local partners within the refugee community and discuss the specific preferences from the local women refugee community, with an understanding that Muslim women represent a heterogeneous group regarding nuanced belief systems for health care provider and setting preferences and must be key stakeholders in any successful CBRP development.
- Ensure gender-appropriate, direct contact providers for CBRP in the community and a “safe space” for “women only” to reduce re-traumatization and to improve cultural sensitivity for Muslim women refugees.
- Provide extra support for literacy and translation services to meet the diverse language and education-level needs of the Muslim women refugee community.
- Provide child-care onsite and transportation (or cost of child-care) to women refugees that is respectful of time, place, safety and culture (i.e. private driven taxi by women only services may be more appropriate and respectful to women than a bus ticket).
- If providing child-care onsite or transportation, make sure it is gender appropriate/acceptable for the subculture (i.e. women only)
- Collect data on CBRP interventions, barriers and facilitators, and data on pre and post health outcomes by age, sex, geographical location, cultural and religious background to provide a quality, nuanced program that meets the needs of the local refugee community.
- Focus on collaborative, team-based interventions for women, where possible and include skilled, explicit feedback to the team based on conflict resolution, motivation, and trust for survivors of trauma.
- Integrate physical activity literacy in English as a Second Language (ESL) or Citizenship Programs to assist with motivation and time management.
- Provide alternatives with varying type, frequency and duration of CBRP interventions for physical activity to meet the needs of women who are busy with high levels of household activities.

Long Term Recommendations:

- Create a CBRP with dynamic health intervention education and information (i.e. PA interventions) targets at all levels of the community including: schools, refugee community centers and affiliated religious organizations, and help to improve the image of PA within the refugee community from all levels.
- Form focus groups in the local refugee community (men, women and adolescents) and get feedback regarding each level of the program.
- Discuss specific mechanisms of how to improve the equitable distribution of power for the individual and within the household/family, community, organizations, systems, and host country to improve overall access to quality CBRP interventions for Muslim refugee women.
- Train and certify members from the refugee communities to be professionals in specialty fields related to the CBRP intervention.
- Work with and support community-based organizations to provide and advocate for CBRP interventions

- Work with the community and urban planners for the creation of safe spaces for outdoor and indoor physical activity participation that include culturally appropriate settings, facilities, and easily accessible registration processes with diverse language translations and in person, gender-focused interpreters and translators (i.e. Many Muslim women prefer women health care providers and would also request women translators and interpreters).
- Consideration of cultural norms within the community regarding gender specific to settings and surroundings, sports/fitness attire, and educational tools that are culturally acceptable and available translations to meet the needs of populations that are culturally and linguistically diverse (CALD).

Community-Based Rehabilitation Program Recommendations: "PARTICIPATORY"

- **P**rovide gender-appropriate, direct contact providers for the community and a "**SAFE SPACE**" for the most vulnerable (women, LGBTQIA community, etc.)
- **A**ssess and analyze **DATA** on health inequities and disparities in the community of interest to use for CBPRP focused development
- **R**e-traumatization should be avoided during evaluation, examination and treatment by training all staff in trauma-informed care, GBV and IPV
- **T**ranslation and interpreter services to meet the diverse education needs of the women refugee community.
- **I**dentifying **BARRIERS** and **FACILITATORS** to improve **ACCESS** and include education at all levels of the community (schools, refugee community centers and affiliated religious and social organizations).
- **C**ulturally-Sensitive: (dress codes, gender-based communication, topic taboos, training for all staff involved, settings and surroundings, sports/fitness attire, educational tools that are culturally acceptable with available translations to meet the needs of populations that are culturally and linguistically diverse)
- **I**nclude women in the refugee population from **DIVERSE** age groups, wealth and education levels in the planning process & consult with social worker and other specialties.
- **P**rovide child-care options & transportation (or cost of child-care) to women refugees that is respectful of time, place, safety and culture to improve access
- **A**dvocacy partnership building by investing in scholarships, training, and certification for members from the refugee communities for maternal/women's health/pelvic health to be community liaisons and leaders.
- **T**iming considerations of household burden for women in the community and provide alternatives and varying type, times, days, frequency and duration programs.
- **O**utcomes identify all stakeholders who hold **POWER** and **PRIVILEGE** in the micro (household), meso (community and other providers), and macro (laws, resettlement organizations) levels and **ENGAGE** them to reduce barriers and facilitate access for those who don't hold power and/or privilege.
- **R**esilience building strategies: Focus on **TEAM-BASED INTERVENTION** options for women (i.e. prenatal classes that work on team activities/exercises) works on- conflict resolution & building back **TRUST** for survivors of trauma.
- **Y**ears of Commitment: Long-term, sustainable program development is the goal. One that builds trust, establishes connections to improve access to prenatal/postpartum/pelvic health and wellness providers and programs and advocates for women's health issues (IPV, GBV, etc) on a larger scale through valid, quality, culturally sensitive, dependable, and gender-focused community-based programs for prenatal/postpartum/pelvic rehabilitation.

CONCLUSION

Consideration of a dynamic, collaborative, and participatory driven model that investigates the micro-level, meso-level, and macro-level stakeholders and structures is central to any CBRP program that seeks to move toward a progressive, gender-focused provision of care aimed at reducing health inequities for vulnerable populations. Program coordinators, providers, and administrators should focus on improving the program accessibility through relaying program information importance and benefits to varying levels of dissemination throughout the community.

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