Journey to Health: (Re) Contextualizing the Health of Canada's Refugee Population

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Existing literature on refugee health has often focused exclusively on either the post-arrival or pre-arrival experience. We believe the totality of each individual social identity should be acknowledged, including life prior to becoming a refugee. Thus, health status must be contextualized within pre-arrival health status and living conditions, health-care access, flight experiences, combined with post-arrival status: a fluid journey-to-health arc. The following article offers a holistic view of refugee health as an outcome of the entirety of this journey captured in a series of in-depth interviews with long-term, established service providers in Hamilton, Ontario. Our findings illustrate the importance of viewing health issues within the context of time and space. Refugees embark on fragmented journeys, leading to multiple challenges for providers, such as limited case histories, the absence of documentation and cultural (in)competence in terms of practice.

Keywords: Immigration, Canada, Refugee, Health

Introduction

Canada is one of nine Western countries that annually sets an objective for the number of refugees entering the country, with approximately 10–15 per cent of the roughly 225,000 annual immigrant arrivals entering Canada as refugees. A large body of empirical research and policy exists on immigrant integration in Canada; however, studies on refugee integration are scarce or, alternatively, many are limited to reporting on one specific refugee community (Yu *et al.* 2007).

The health of refugees in Canada is typically contextualized around their post-arrival experiences (exceptions include Clinton-Davis and Fassil 1992;

Muecke 1992), including eligibility for health-insurance programmes such as Canada's Interim Federal Health programme (IFH), health-care access and barriers to care (McKeary and Newbold 2010). However, to consider health concerns/status only in the post-arrival context is to assume the individual is 'born' only in the present and to erase or discount their past. Instead, we argue within this article that the health of refugees must be viewed as part of a continuum in order to reflect the relative disconnect between their 'old' and 'new' lives, the loss of formal medical records (if these ever existed in the first place), the relative difficulty of (re)constructing health records when faced with language barriers, lack of interpretation services, time constraints, shortage of resources and multiple other challenges and/or the desire on the part of refugees to relinquish the past out of the fear that too much knowledge may compromise their ability to remain in Canada. Yet, the literature has rarely considered this complete biography, which frames the lived health status of each individual refugee.

The current article, drawn from in-depth provider interviews, expands the discussion of refugee health by contextualizing post-arrival health relative to pre-arrival, in-transit and post-arrival experiences. In essence, it recognizes that the health status of a refugee is a 'journey' and one that rarely leads to positive health outcomes over both the short and long term.

Background: Diversity of Origin and the Impact of Cultural and Social Identity on Health

It is generally recognized that refugees have differential health experiences and needs than the broader immigrant population (De Maio 2010), with the stress of the circumstances that led to becoming a refugee having implications for mental and physical health. Forced to leave their country of origin, they are often separated from family members and have typically lost their material possessions, wealth and status (Dillmann *et al.* 1993). For individuals and families forced to transit through or reside in refugee camps, violence, crowded conditions or food (in)security will have a detrimental impact on health, with approximately 60 per cent of refugees experiencing war, torture and/or imprisonment as part of their journey (Watters 2001; Derges and Henderson 2003; Koehn 2005; Proctor 2005). Numerous other studies have noted mental health issues among refugees as a result of camp conditions, bereavement, separation of family and friends, loneliness and lack of acceptance in the country where they resettle (Sinnerbrink *et al.* 1997; Whittaker *et al.* 2005). In particular, PTSD has been highlighted as a significant concern for refugees (Mollica *et al.* 1997; Beiser and Wickrama 2004; Blight *et al.* 2006; Keller *et al.* 2006; Silove *et al.* 2007; Beiser 2009). However, research has highlighted refugee resettlement cannot be understood without consideration of numerous pre- and post-migration stressors beyond those that are acutely post-traumatic (Porter and Haslam 2005; Ringold and Burke 2005; Porter 2007; Maximova and Krahn 2010; Miller and Rasmussen 2010). Certainly, trauma has a mental health impact.

Post-migration living difficulties have even greater predictive salience (Sinnerbrink *et al.* 1997; Keller *et al.* 2006; Schweitzer *et al.* 2006; Silove *et al.* 2007; Birman and Tran 2008; Schweitzer *et al.* 2011). Post-migration stressors include the challenge of adapting to a foreign environment, possibly a different language and culture, problems of (un) (under)employment, economic hardship, discrimination, separation from family and friends and an altered or absent social network (Keyes 2000; Burnett and Peel 2001; Lawrence and Kearns 2005; Maximova and Krahn 2010). Indeed, a significantly greater proportion of refugees report physical, emotional or dental problems following their arrival in Canada than the immigrant population in general (Statistics Canada 2005) and refugees are more likely to transition to poor health (Newbold 2009). In part, these health outcomes are a manifestation of the conditions refugees experienced in their origin countries or refugee camps, including inadequate health care and poor nutrition, HIV and violence (Harrison *et al.* 1999). In addition, poor health is exacerbated by systemic barriers including language, costs and the lack of insurance, lack of awareness of services, difficulty finding a doctor and cultural differences that may limit access (Wahoush 2007; Asanin and Wilson 2008; Pottie *et al.* 2008). Clearly, refugees are not a homogenous group: differences of birthplace, route taken and conditions of the journey, arrival status, settlement policies, cultural and socio-economic status, amongst other variables, will all have differential impacts for health status and access to health care.

In working with refugee patients, health-care providers must navigate between shifting policies and programmes as well as issues related to insurance, trust and language, amongst other issues that are specific to the refugee population (McKeary and Newbold 2010). Moreover, despite the primacy of the biomedical system within Western culture, illnesses are embedded with cultural meaning and experiences (Conrad and Barker 2010), meaning that different notions of health and disease can exist across individuals and groups. Moreover, refugees are more likely to disproportionately suffer from tuberculosis, malaria, hepatitis B, malnutrition, anaemia, leprosy and intestinal parasites, among other problems (Harrison *et al.* 1999).

For the health-care provider, understanding the complexities of a patient's health is typically based on a comparatively short assessment that is devoid of their story and history, missing opportunities to develop trust and understanding. The following article recognizes that the health of refugees is instead reflective of their journey. As such, refugee health is far more multidimensional and nuanced than would typically be revealed post arrival.

Methods

We contribute to the growing body of refugee literature informed by a social health perspective and, more specifically, the theoretical underpinnings of the social production of illness paradigm. The perspective contends diseases are socially produced, constructed and distributed based on the key social

variables of class (SES), gender and ethnicity, as well as the ways in which professional knowledge/practitioners define disease categories (Walters *et al.* 1995; Birenbaum-Carmeli 2004; Rhodes *et al.* 2005). The perspective has focused on the impact of economic and social equity for individual health status, as well as access to health care services. Thus, our findings have policy implications at the local, provincial and national levels.

There are many methodical challenges encountered when conducting research on refugee health, including representation, sampling, access (physically and linguistically), lack of trust of outsiders and the possibility of re-traumatization (Jacobsen and Landau 2003; Spring *et al.* 2003; Mackenzie *et al.* 2007). Some studies reveal participation in the research process (especially trauma-related research) can have health benefits for refugees both individually and structurally (Newman and Kaloupek 2004; Porter and Haslam 2005; Bloch 2007; Guerin and Guerin 2007; Maximova and Krahn 2010; Sulaiman-Hill and Thompson 2011). The opportunity to verbalize traumatic experiences allows the individual the opportunity to create 'meaning' and may initiate conversations with others, leading to a healing process (Newman and Kaloupek 2004). Research holds the potential for structural improvement of health care, through both the development of interventions for specific refugee groups and increasing understanding of the effects of trauma and forced displacement (Ellis *et al.* 2007).

The following study is based on a series of semi-structured, in-depth interviews with key service professionals in both the social service and health fields in Hamilton, Ontario, examining both health and health-care issues. Hamilton is an industrial city close to Toronto, with a 2016 population of approximately 500,000. Due to a lower cost of living, and the availability of diverse services/programmes, it is attractive to immigrants and refugees (including 'secondary settlement') exemplified by over 65 spoken languages. As one of six designated sites for Government Assisted Refugees (GARs) in Ontario, Hamilton receives double the national proportion of refugees (approximately 420–450 persons annually) (Wayland 2010). Recent refugee arrivals to Hamilton include arrivals from Sudan, Iran, Afghanistan, Liberia, Ethiopia, Eritrea, Somalia, Congo, Burundi, Rwanda, Iraq, Myanmar and Bhutan.

Individuals interviewed for this research included executive directors, program managers, nurses, physicians, health educators, settlement workers and community health centre employees. The decision to focus on the expertise and experience of long-term local service providers parallels other studies (Keyes 2000; Bloch 2007; Guerin and Guerin 2007; Sulaiman-Hill and Thompson 2011). Subsequent work (discussed elsewhere) interviewed key community informants and individual refugees. This multi-tiered process allowed the creation of a historical and current map of the refugee population locally, enabled the findings to be representative, and allowed the research team to develop rapport within vulnerable groups, utilizing trusted sources (Atkinson and Flint 2001; Jacobsen and Landau 2003).

We chose qualitative methods, since they attempt to capture and communicate another's experience and worldview, making them appropriate for an exploratory study (Lather 2009; Singer and Adams 2011). In-depth interviews are understood as an especially appropriate methodology for health-related research amongst culturally and linguistically diverse groups (Singer and Adams 2011). Respondents were offered anonymity and research data was coded and recorded in order to ensure confidentiality, especially given the comparatively small pool of potential respondents in the city. One of the authors used her knowledge to identify and recruit key personnel via letters of invitation, resulting in 100 per cent acceptance. A total of 14 interviews were conducted and recorded, resulting in approximately 25 hours of transcription and over 20 years of Hamilton 'reception' history.

The interview script asked participants to describe their role in the refugee community via their past and current employment position(s), length of time working with newcomers, refugee community and client demographics, identification of both barriers to care and priority health needs, the impact of cross-cultural health beliefs and definitions, use of alternative and preventative care, and the challenges of working with scarce resources. Transcripts were thematically analysed using discourse analysis (Cope 2005). Data was analysed for emergent themes, relevance and significance, as well as identifying the primary narratives associated with refugees/newcomers, sometimes referred to as an analysis of narratives (Clandinin and Connelly 2000; Riessman 2008).

Results: The Pre-Arrival, En-Route and Post-Arrival Journey to Health

Analysis of the transcripts reveals that refugee health is a 'journey' from pre-'refugee' to pre arrival, in transit and, finally, post arrival. Embedded within these individual but connected segments of arrival are concepts including cultural collision, cultural compromise and power differentials throughout the journey that constrains and limits their health (Fadiman 1997).

Pre Journey

If we wish to acknowledge that health is a continuum, we must start by metaphorically returning the refugee to her or his home country and to a time before the refugee label was applied. Here, health-care options may be limited and health status may already be compromised even before becoming a refugee. Both health status and access to health care may, for example, be compromised by conflict; cultural roles and expectations; environmental conditions; loss of family members who provide security, income or food; limited budgets and poverty. Poverty, for example, means that individuals may not have had access to physicians, or only used them when they were sick, and/or their origin country may have only had rudimentary health-care services and non-existent preventative care, while experiencing malnutrition:

I think people in many countries and again I'm going to go back to my culture...is that you go to see a doctor only when you needed to.... You don't even need to go to a family doctor. If you want to go to a specialist you go directly to the specialist if you have the money.... But I have to say that people in my country had never seen a doctor because they live in villages that were too far away from the city, we only had five hospitals in the whole country (#500).

For many, being a refugee starts with the act of fleeing their home in search of safety and starting on a precarious journey with no certain end point. Fleeing their home, *pre-migration* events may include experiences of war trauma, physical and emotional torture, imprisonment, and loss of family members to displacement or death and fear for personal safety (Mollica *et al.* 2002), while health care is often interrupted or there is a lack of health care during the journey:

So, if we look at it in that way, ...whether we're talking about diabetes before somebody came to the country as a refugee. They may have been a diabetic or they may have had hypertension, and the process of that journey from where they were exiting to where they are landing has interrupted the management of that...because have not had access to any care in those travels, except for probably TB, because everybody who goes to get on the plane has to be tested (#505).

Journey: In Transit

Long wait times, poor camp conditions that foster disease transmission, limited medical resources and disjointed health care during the journey are likely to have negative and long-term implications for health. During our interviews, providers focused on the impact of the 'route' taken and borders crossed by the refugee prior to arrival (Harrison *et al.* 1999):

from the countries that they are staying as a second country for settlement, you know, there is lots of challenges they still may face, you know, maybe still they are not safe in that country. Still they don't have food. And this all makes people to worry and be stressed and get sick easily (#503).

Thus, the routes that the journey to Canada takes may result in differences in health, even when individuals share the same nationality:

and each Afghani, you know, they are...they are different type of client I would say. They speak same language. But based on this ten years or fifteen years of being refugee in that country it affect their even personality and even their needs, their health, everything. Afghans...who's coming from Tajikistan they have different sickness: heart problems, stomach. Who's coming from Ukraine or Moscow or Russia they have mostly different health issues. Who's coming from Pakistan they have different issues related to their health, to their mental, to...even education, you know (#503).

A critical pre-migration/in-transit factor for health is time spent in a refugee camp. Those who transit through refugee camps may experience inadequate health care, malnutrition, lack of shelter and high rates of infectious diseases (Clinton-Davis and Fassil 1992; Baldwin 2007): 'If they come from a refugee camp there will be a different health status. [Depending] on how long they have been in the camp' (#502).

Although these refugee camps may be seen as 'safe' interim locations, the reality is often vastly different. Escaping one threat, refugees often find that the camps present other threats to their health and wellbeing:

The stress in the refugee camp is very difficult for them They have not only been victims of torture because of political, social, religious beliefs and so on. But it's also they become victims in the refugee camp. They may be victims of rape, women may be raped, there may be some domestic violence and so on (#502).

Individuals labelled internally displaced persons (IDPs) have even more limited options in camps, since they are not protected by international refugee laws and have little access to international assistance, including health care. Others may have lived in camps run by the United Nations High Commission for Refugees (UNHCR) or other UN agencies. Despite best efforts, camps and settlements often have inadequate supplies of water, food, sanitation and shelter, which may reflect political interference or economic barriers to getting supplies to the camps (Lischer 2005). Not surprisingly, many refugee camps see frequent outbreaks of malaria, dengue fever, cholera and a high incidence or prevalence of tuberculosis, as in the case of the Karen refugees from Thailand who lived in camps in northern Thailand for over a decade (Baldwin 2007), with over-crowding leading to multiple health complications:

You know, I would say if I am a health care provider I would put in priority for refugees who's coming from the camp. High priority. From dental, if you talk to them you see From dental to the rest of their body, you know, they need It's because they never had access. If they got sick some of them even they never had aspirin to take (#503).

Under the Refugee Convention, access to health care in a camp should be equivalent to that provided by the host country, meaning that refugees should therefore have basic care and vaccinations while in the camp but they are unlikely to receive care for complex situations. In many cases, health services in the camps are significantly less than those found in the host country (Duggan 2009) and clearly not at a standard observed in Canada or other developed countries:

So, I mean even in terms of the Afghanis, a lot of them, maybe while they were in Afghanistan didn't have a lot of access. . . . And you know, there's all kinds of persecution and they felt they were mistreated. While they were there they did have access to hospitals and health care (#508).

The camp experience also changes familial relationships and societal roles, often making it difficult to re-establish these patterns later in the post-arrival period. In particular, the experience may 'rob' some children of their family or, at a minimum, of their childhood and transform them into traumatized adults, who later must readjust to the dependent-child role:

They know how to survive. You know, survival skill. We have experience when mostly refugee single mothers who came from Iran, ... Afghanis. The boy ... if the oldest son is twelve or thirteen, that is the father of the family and that is the person who feed the family. Now, that child I think how much they went through and what kind of experiences. And to change his mind and to bring him to a child is impossible (#503).

You know, from all our studies and experience all refugees that is coming after conflict and war, children is the most affected people in the family. Children, mostly if they see something bad ... if they see somebody was killed or they see how people they are fighting. ... For children it's nightmare. ... And it is with them and it will be forever from my experience (#503).

The refugee process can be a long, drawn-out affair, potentially consuming years and contributing to stress and poor health, magnified by violence and lingering fear of further displacement or being expelled to the homeland. Not surprisingly, health status is also dependent on length of time in the camp. For those that have only temporary residence in camps, their health status more than likely reflects a mix of conditions in their country of origin, health status achieved in the host country, the length/conditions of travel to the camp, host country reception and food, water, shelter and health-care provision in residence. For longer durations in camp, health status depends on such things as the ability to grow food, to work/earn income, to enter/exit camp and access to education, the political power structure of the camp and level of threat:

With some people, they haven't been in school for a very long time, or at all, so even navigating in literacy in their own language, never mind in English language becomes a huge, huge challenge (#505).

We had Sudanese and Somalis from Dadap, mostly Dadap come from Nigeria. You know, in Dadap camp there is one hundred and forty thousand (140,000) refugees they are waiting. And for them to come here—because each year they are just recruiting two thousand (2,000) people. And for a person who's here and he is named in the list ... in the bottom of the list it will take twenty years waiting list. And in this twenty years lots of things can be happening, ... parents can be dying. Or there will be new born children or marriage (#503).

Given the length of time to process applications, individual health status changes and worsening health are often blamed on the stress of the process:

One of them had had cancer before, and ... she won the refugee hearing. But I, I, there are some people that handle that period relatively well. There are some people that really have a hard time. Like nightmares, insomnia, headaches, all

of that. This woman now, she has cancer in the other breast, and she thinks that that stress probably triggered the cancer. . . . And the other one thinks that when she was refused and she was waiting for the humanitarian to be processed, she thinks that that had an impact on her health (#500).

Just 72 hours before leaving a camp, each refugee bound for Canada has a 'Pre Departure Medical Screening' (PDMS), which includes a medical history and physical examination (Baldwin 2007). The intent is to assess the basic health of refugees, including the presence of chronic conditions and/or infectious diseases, allowing those with special health needs to be linked with appropriate health services after arrival. Unfortunately, assessments while in camp can be difficult, and difficulties in communication between various government agencies during the period of travel to Canada or post arrival, along with communication between partners and settlement agencies, means that important health information is often lost or not used to its full potential.

Post Migration

It is widely recognized that the process of arrival is a demanding process with an uncertain conclusion. Displacement must be understood within the context of the economic, social and cultural conditions from which refugees are *displaced* and into which refugees are *placed* (Beiser 2009):

Each . . . country the way they provide services or the way they accept refugees create that refugee, . . . culture . . . for the group. [So] . . . to work with them you have to know their background. . . . And that background . . . for many years mean new culture, new environment for refugees (# 503).

and it's not only the war-torn country. You think of the refugee camp and that. I think it's anyone that gets pulled out of their country and has to flee, for whatever reason. There is a need to address that. Too often these people are expected to arrive in Canada and be fine, right?" (#506).

In varying degrees for refugee arrivals, the process is more of a rupture, often with a violent relocation and reshaping of their life and the need to start over in the destination country with few resources (some more than others) and negative impacts for their health:

I mean, I think immigration is generally, especially if you're immigrating to a place where you don't speak the language is right up there on the list of the most stressful things that can happen to a person, death, divorce, and immigration. The big difference with refugees is the experience of persecution or trauma and the fact that they often arrive with far less resources and they didn't choose to come. I mean the fact that this wasn't in their life plan, is huge (#507).

So try to walk in those shoes, try to think, how would you feel, if you were forced to leave your country one day, and be put in a new place and not have those supports that you need to, to be able to swim those waters, but you have

to learn to swim before you're thrown in the water, you know? Otherwise you drown, and you can drown in so many ways in this...country. The resources might be there but they don't have the knowledge, especially refugee claimants, who don't know they have access to doctors...people who think if they go and ask for help, they are going to be refused, because they are already a burden to society (#500).

If they are asylum refugees, the instability and uncertainty of the outcome of their refugee status can be very stressful, leading to numerous mental and physical problems:

So probably, the majority of people that we worked with were refugee claimants. And that's a big step. I mean there's a lot of uncertainty. There's a lot of fear. There's a lot of anxiety and stress just connected to the fact you still have to undergo your refugee hearing (#507).

Okay, so they had to go through the process. And I have to say from those people who came in 1987, 1988...some of them took about eight to ten years to get status in the country. That led to stress for lots of people...That's the time when you see people having the most migraine headaches...stomach aches, all kinds of pains and aches...insomnia, depression, low mood. People—have problems concentrating, a lot of crying, lot of nightmares, people who have left children behind, it's a horrible nightmare (#500).

Beyond individual health effects, the stress of the refugee process may also include the abuse of some in the destination country (i.e. rental agents) due to cultural unfamiliarity and lack of supports, thus widening the circle of health effects.

Post arrival, health-care providers are challenged by the lack of continuity of care amongst refugees who may have moved from their birthplace through refugee camps and ultimately to their final destination, with different levels, types and availability of health care in each case:

“Yeah, I mean I'd still say the Somalis were probably, as a group, the sickest people that I've ever worked with,..., just because that group that we saw...had been without health care for like ten or fifteen years. You know, almost all of them had had malaria, had had Tuberculosis, had had some kind of Hepatitis, all kinds of intestinal parasites (#508).

Even though some refugees will arrive with health files (such as PDMS files) and other documentation, the files are often incomplete and providers are often forced to reconstruct health histories:

The other barriers are just an absence of continuity around health information from previous experiences. And not having that understanding of what actually has happened. You have to construct, sometimes, many times reconstruct and, in most cases we listen to families and to the people. Mom's know what's happened with their kids. They may not know the proper name for it but when you talk to them...they know (#505).

On arrival in Canada, refugees frequently encounter barriers to health care (McKeary and Newbold 2010). Although barriers are similar to those observed amongst the broader immigrant population, refugees are typically more vulnerable given their complex and inter-related issues of pre- and post-arrival experiences, food, poverty, shelter, legal needs, violence, transportation and employment priorities (Beiser *et al.* 1999; Harrison *et al.* 1999; Beiser *et al.* 2002). There are often shortages and long waiting lists for specialized health-care services, such as counselling for torture victims.

Despite acknowledgement that refugees with health needs should be linked to local providers, there is a surprising lack of health care after arrival for many new arrivals, reflecting physician shortages and waiting lists, along with the refusal of some doctors to see refugees given the time needed to ensure compensation (including insurance issues as refugees and providers alike work through the bureaucracy of the IFH programme) and language difficulties:

Even family physician, that...are accepting new patient. But when you call them they say: 'No, they will accept them if they speak English.' The meaning is 'no'. You know? This is barrier. Big, big challenge. [Especially] if we have a person who really needs to have a family physician (#503).

there's times when there's nobody receiving new clients in the inner city at all and so it's just a challenge (#505).

The lack of connection to the health system results in 'doctor switching' or using walk-in clinics. In both cases, if the client profile is not connected and the health history is dispersed and fragmented over multiple providers, both care and continuity of care are compromised:

If they can't find a doctor, they don't know how to find a doctor. Then they mostly get information from their uh...from their neighbours (#509).

Walk-in clinics are, for that reason, [are] getting quite popular with these immigrants who do not find doctors for x number of months or even years (#509).

Language (Pottie *et al.* 2008) and trust issues (Hynes 2003) are also major barriers that hinder health-care provision. Providers and clients alike struggle to convey ideas and meanings, and there may be reluctance to 'share' personal history for fear of the impact on their refugee claim. Trust is a major barrier for many refugees due to past experiences and the belief that their current residence is 'tenuous' (Hynes 2003). Trust between refugee and provider requires time and consistency to develop and may be difficult to achieve within our current 'collapsing' health-care system:

Or people who are new and are not quite comfortable, after their experience, particularly as a refugee, that I'm going to show anybody anything. Because I'm not sure where I'm going to end up, how that's going to impact, are you government or not. The last time I showed someone my papers this is what happened to me. So sometimes there's that concern (#505).

Refugees may also require access to employment services, shelter and specialized health services, including mental health and counselling. Resettlement in the new country can offer safety but may also result in a loss of economic and social status. Refugees are often dealing with employment deskilling and credentialism issues, both of which have implications far beyond immediate socio-economic status by mediating physical and mental health and creating multiple health risks (Nolan 2002). Several respondents commented on the fact that health *per se* was not an immediate priority for new refugee arrivals:

It's hard. It's hard because when they come as new [migrants], in the beginning there, . . . it's on their mind to get a place to stay. That's very important priority. Understand the culture, get a job, get going and to basically find their way around. So health is put sort of on the backburner, if you will (#509).

Reinforcing the notion that health is a comparatively low priority, another respondent commented that:

The social determinants of health so employment, housing, and family reunification. Getting through the immigration system—those key social needs are, I would say, are the health determinants for refugees in the post migration phase (#507).

Finally, preventative care that is a standard procedure for many Canadians is a low priority for many new arrivals. The concept of preventative health care may be unknown, not part of the health lexicon of new refugee arrivals or be lacking in their home country or refugee camps. For others, it may not be a culturally supported practice:

For newcomers in Canada it isn't a priority for two reasons. One, I need to concentrate, if I am a newcomer, on securing income for my family. I need to secure food for my family. So preventative measures are going to be at the bottom of your priority list because there are other things. Ok, I need to learn English, if I don't learn English I won't be able to work, if I don't work, I don't have food for my family. So for me having a pap smear having a mammogram, that wouldn't be a priority (#502).

Discussion and Conclusions

Amongst refugees, it is indisputable that critical health issues are often presented at the time of arrival, or arise shortly after arrival in Canada. Moreover, pre-arrival and transit health status will be modified not only by access, but also by social and cultural status, violence, family separation and reunification, acceptance status (government assisted versus refugee claimant) and 'guarantee' of residence, leading to a need to consider health as a continuum:

The other barriers are just an absence of continuity around health information from previous experiences.... You have to construct, sometimes, many times reconstruct and, in most cases we listen to families and to the people. Mom's know what's happened with their kids. They may not know, the proper name for it but when you talk to them...they know (#505).

Despite significant changes to Canadian refugee policy since the completion of this project, including Bill C-31(which included provisions defining safe countries, delayed entry and changes to the refugee claim and protection process), changes to IFH coverage that severely curtailed health coverage to refugees for a period of time and further changes to policy with the election of the Trudeau government in late 2015, our article builds upon the refugee health literature. In particular, researchers and service providers alike believe the short- and long-term consequences of changes to the various policies and programmes that directly impact refugees were detrimental to their health. Any impacts, however, will be in addition to the current existing barriers/challenges discussed here.

This article contextualizes the health status of refugee populations within the lived context of time, space and personal biographies, recognizing that the health of refugees is a 'journey' from pre 'refugee' to pre arrival, in transit and, finally, post arrival in the destination country. It is a *journey arc* with fragmented and unstable health status from many variables, including violence, mental stress, inadequate health-care resources and living in varied conditions from multiple settlement countries and refugee camps. Thus, the health status and need for health services within refugee populations cannot be considered as only 'current' or existing health status, but rather as a continuum of experiences.

The results reveal that refugees experience aspects of cultural collision, cultural compromise and power differentials throughout their journey that constrain and limit their health, echoing themes developed in Fadiman's (1997) *The Spirit Catches You and You Fall Down*. Cultural collision, for instance, is captured by differential roles between home and destination societies, exemplified by cultural differences in gender roles, the causes of disease and illness or the recognition of the importance of preventative care. Knowledge about illness and disease that is constructed and developed by the Western medical system clashes with traditional or cultural understandings of disease. The result is conflict with Western culture and practices, particularly Western medicine, leading to misunderstandings between physicians and their patients.

Power differentials, while commonly exemplified by the physician-client relationship, also include changing family and societal roles experienced during the journey as well as political power experienced in refugee camps, all of which may remove opportunities for refugees to make choices regarding their health. Power differentials, where they exist, may limit opportunities for the development of trust between providers and clients.

Cultural compromise may provide an option to enrich the health experiences and outcomes of refugees. For many refugees, health is entwined with their story and their journey. As such, understanding these individual stories and creating space for their voices within the health-care setting are vital to successfully engaging health resources and ultimately improved health status. For many, however, the opportunity to tell their story is limited. Upon arrival, health-care professionals do not necessarily receive a complete medical history due to time constraints and a lack of resources, meaning they are unable to investigate or discern each individual's 'health story'. The scarcity of good interpretation services, or difficulty in dealing with limited language abilities (both provider and client), adds to consultation costs and time, and lowers the quality of care. Likewise, refugees may be unwilling or apprehensive about telling their stories and sharing their health concerns due to fears of deportation. Burdensome paperwork, limits to health-care provision, along with unclear and shifting eligibility rules associated with Canada's IFH program further limit health-care provision. Additional issues of poverty, employment, isolation, sexism, racism, xenophobia, access to transportation, etc. either lead to or exacerbate these barriers. Consequently, the 'story' is lost and both provider and client are limited in their relationship by the disjointed and inadequate health system. Pushing physicians and service providers beyond concepts such as cultural competency, physicians must, therefore, take the time to listen and consider their patient's stories about their illness, including aspects of traditional knowledge and origins of illness, reflecting Kleinman's (1980) notion of asking the "What, Why, How and Who" questions. In encouraging such interaction, trust between providers and their patients is developed. Moreover, physicians should consider and allow cooperation in the healing process—a process that might imply that both Western and non-Western medicines are used.

Ultimately, health-care providers must be able to draw upon resources that can address a range of cross-cultural issues to meet the needs of their patients—a need that extends beyond the refugee population. Due to Canada's humanitarian commitment, the country will continue to receive refugees with complex health needs, exemplified by the arrival of some 25,000 Syrian refugees in late 2015 and early 2016. Like the subjects of this article, the Syrian arrivals had experienced war, trauma, refugee camps and acculturation in their new country, with their health impacted by each step of their journey to Canada. As such, Canada should and must be prepared to provide quality health services within the limits of its resources. However, to adequately service this population, the health-care system must better acknowledge individual refugee stories and draw the crucial connections between individual health status and the journey undertaken.

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