# Caring for refugees and newcomers in the post–COVID-19 era

## Evidence review and guidance for FPs and health providers

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## Abstract

**Objective** To guide clinicians working in a range of primary care clinical settings on how to provide effective care and support for refugees and newcomers during and after the coronavirus disease 2019 (COVID-19) pandemic.

**Sources of information** The described approach integrates recommendations from evidence-based clinical guidelines on refugee health and COVID-19, practical lessons learned from Canadian Refugee Health Network clinicians working in a variety of primary care settings, and contributions from persons with lived experience of forced migration.

**Main message** The COVID-19 pandemic has amplified health and social inequities for refugees, asylum seekers, undocumented migrants, transient migrant workers, and other newcomers. Refugees and newcomers face front-line exposure risks, difficulties accessing COVID-19 testing, exacerbation of mental health concerns, and challenges accessing health care, social, and settlement supports. Existing guidelines for clinical care of refugees are useful, but creative case-by-case strategies must be employed to overcome additional barriers in the context of COVID-19 and new care environments, such as the need for virtual interpretation and digital literacy skills. Clinicians can address inequities and advocate for improved services in collaboration with community partners.

**Conclusion** The COVID-19 pandemic is amplifying structural inequities. Refugees and newcomers require and deserve effective health care and support during this challenging time. This article outlines practical approaches and advocacy priorities for providing care in the COVID-19 context.

## Editor's key points

- A large proportion of refugees have faced forced migration, precarious isolation, substandard living conditions, and limited health care. Layered onto pre-existing trauma and a multitude of postmigratory stressors, the coronavirus disease 2019 pandemic has brought about further loss of access to settlement services, loss of employment and income, and prolonged social isolation, each of which exacerbates mental and social strain.
- Many refugee patients have struggled to access their health care providers and familiar social supports during the coronavirus disease 2019 pandemic, and continue to grapple with navigating a constrained health system. Obstacles include limited in-person visits and a transition to virtual care and online services compounded by existing language barriers, inconsistent access to and familiarity with technology, and a range of social stressors. Clinicians must remain alert for depression and anxiety and ensure a range of care options and platforms are available, and can help patients connect to social and community programs to address underlying social and economic stressors.
- Overcoming barriers requires new and creative solutions; dynamic interdisciplinary teams, perhaps within more specialized or alternatively funded clinics; and case-by-case approaches. Innovations should be codesigned with patients to ensure strategies are responsive to their needs and priorities.

The coronavirus disease 2019 (COVID-19) pandemic has exacerbated inequities related to health and socioeconomic status for refugees and newcomers around the world.[1] **Box 1** defines some categories of migrants and clarifies the health and social support to which they are entitled.[2,3] Despite comprising approximately 25% of the population, refugees and newcomers accounted for 43.5% of Ontario's COVID-19 cases in the first half of 2020. At the same time, rates of COVID-19 testing in Ontario were lower for refugees (3.4%) compared with Canadian-born individuals (4.4%).[4] Employment in front-line work with limited job protection and safety measures, high-density housing situations, and greater reliance on public transportation put refugees at higher risk of contracting COVID-19.[5] Temporary foreign workers and undocumented migrants may be at even greater risk, given their precarious work, living, and immigration circumstances.[6] Indeed,

**Box 1. Population definitions**

**Refugees** (including GARs and PSRs, who receive resettlement assistance from the federal government and organizations or groups of individuals during the first year of resettlement, respectively) are individuals who reside outside their country of origin owing to fear of persecution for reasons of race, religion, nationality, or social and political affiliation. GARs and PSRs are resettled in Canada as permanent residents and have access to resettlement programs and the IFHP upon arrival and are soon transitioned to provincial health care coverage

**Refugee claimants and asylum seekers** are individuals who have made a claim for protection as a refugee upon or after arrival in Canada, sometimes waiting years for their Immigration and Refugee Board hearings. They receive health care coverage through the IFHP, but face barriers to accessing social and health services

**Undocumented migrants** are individuals who are not granted (or are no longer granted) permission to reside in Canada, whether they have entered the country regularly or irregularly. This group includes undocumented workers who participate in the Canadian labour force without a work permit. They have very limited access to government and other social support and to health care

**Temporary foreign workers** are individuals who temporarily reside in Canada for work-related reasons in the observed calendar year. Temporary foreign workers receive temporary provincial health cards contingent upon their ongoing employment with the same employer. They have little social and settlement support and thus face precarious health care access, employment, and living conditions

GAR—government-assisted refugee, IFHP—Interim Federal Health Program, PSR—privately sponsored refugee.
Adapted from the Canadian Council for Refugees[2] and Government of Canada.[3]

COVID-19 has had a disproportionate impact on the health of refugees and newcomers[7] and left many undocumented migrants without access to health care.[8]

Refugees have long faced individual, institutional, and systemic barriers to care. These include financial constraints, language barriers, pre-existing trauma, systemic racism, and care coordination challenges.[9,10] Public health's redistribution of resources to address the pandemic is often at the expense of refugee health priorities, including screening for and management of both infectious and chronic diseases (eg, tuberculosis, hepatitis B and C viruses, hypertension, diabetes), immunizations, and mental health care. Public health restrictions for COVID-19 have also increased barriers to health care and core resettlement services and have resulted in broken service connections.[11] Notable COVID-19 outbreaks in meat processing facilities[12] and among agricultural workers[13] have highlighted the vulnerability of newcomer workers. Further, loss of employment has exacerbated existing housing, financial, and food insecurity for many. This article reviews the existing evidence and provides practical guidance for front-line clinicians (**Box 2**).

## Case descriptions

*Case 1.* Mrs G. arrived in Canada with her 5 children a year ago as a refugee from the Democratic Republic of the Congo. Neither Mrs G. nor her family have been to your clinic for 6 months. She presents today with her daughter, unannounced, saying she had been unable to reach clinic staff. With her limited English and your limited French, you are able to determine that her daughter developed a cough weeks ago, but that she has been out of school since last March, when Mrs G. lost her job.

*Case 2.* Mr N. and his boyfriend arrived in Canada 1 year ago as refugee claimants from Ukraine. During his scheduled telephone visit, through a telephone interpreter, Mr N. shares his anxieties about reaching out for care for his cough and fever symptoms, particularly as he is not yet a permanent resident. He does not know where to go for testing and is afraid of being fired if he misses a shift at his warehouse job.

## Sources of information

The authors, all with the Canadian Refugee Health Network, shared clinical COVID-19 experiences, reviewed literature such as the eCOVID-19 guidelines and refugee health guidelines, and interviewed people with lived experience of forced migration (**Box 3**).[9,14-16]

## Main message

Many refugee patients have struggled to access their health care providers and familiar social supports, and continue to grapple with navigating a constrained health system. Most newcomers have faced obstacles, with limited in-person visits and a transition to virtual care and online services compounded by existing language barriers, inconsistent access to, and familiarity with, technology, and a range of social stressors. Overcoming these barriers has required new and creative solutions; dynamic interdisciplinary teams, perhaps within more specialized or alternatively funded clinics; and case-by-case approaches. Innovations should be codesigned with patients to ensure strategies are responsive to their needs and priorities. We outline evidence and recommendations below, and local innovations are provided in **Table 1**.[9,15-21]

*Encourage COVID-19 prevention.* Health professionals can play a crucial role in informing patients about existing evidence-based public health guidelines related to COVID-19, such as wearing masks, physical distancing, and hand hygiene,[15] in culturally and linguistically appropriate ways. Primary care providers can support

**Box 2. Practical tips from primary care practitioners working with refugees and newcomers**

Encourage COVID-19 prevention
- Promote existing public health and safety preventive measures such as wearing masks, physical distancing, and hand hygiene (grade A*)
- Support education about, and access to, COVID-19 vaccines through culturally and linguistically appropriate avenues (grade A)

Promote access to COVID-19 testing, care, and immunization
- Advocate for safe, dignified, low-barrier access to vaccines in trusted spaces close to where people live and work, at convenient times, with simple booking or walk-in options, and with clear messaging that vaccines are free regardless of health care coverage or immigration status (grade A)
- Advocate for community access to testing and care, including assistance with transportation, result retrieval, and rapid turnaround for results, regardless of health insurance or immigration status (grade C)
- Be attuned to the development of local and accessible testing sites for referral when necessary (grade C)
- Seek creative case-by-case approaches to COVID-19 care (eg, use virtual care with appropriate use of telephone or virtual medical interpreters when in-person care or interpretation is not feasible) (grade B)
- Screen for and address social needs to support self-isolation (eg, access to food, income, safe housing) at the time of testing and during follow-up care (grade A)

Support women, children, and families
- Watch for opportunities to engage and offer support, particularly for those families who present infrequently. Discuss and connect refugee women, children, and families to specific supports (immigration, legal, income, educational, food supports, etc) (grade A)
- Explore day-care and school attendance options for refugee children after reviewing existing infection control safety measures (grade C)
- As with all populations, stay alert for heightened domestic violence and mental illness in pandemic times (grade A)

Address stress and mental health
- Recognize and value individuals' prior lived experience and resilience during crises (grade C)
- Sensitively discuss social stressors and provide links to potential resources to address these concerns (grade C)
- With shared decision making, explore a range of options for mental health support and platforms to engage (grade C)

Recognize the potential, but also the limitations, of virtual care with refugees
- Be aware of constraints of privacy and the digital divide (access to technology and Internet; familiarity with digital tools) when engaging with newcomer patients (grade B)
- Advocate for access to needed technology, data plans, and user-friendly platforms (grade C)

Stay alert to particular social needs and advocate for individual needs and system-level change
- Identify social needs of refugees during COVID-19 and connect to available supports to address these challenges (eg, uncertain migration status, risks of front-line work, unemployment, income insecurity, food insecurity, precarious housing) (grade A)
- Advocate for safe, dignified access to care and social support for all, regardless of immigration status (grade A)
- Advocate for strengthened social supports, from income support to living wages and worker protections to affordable housing (grade A)

Encourage return to community and resettlement programs
- Support refugees in reconnecting to social services, educational resources, and community supports as they become available online or in person (grade C)

CTFPHC—Canadian Task Force on Preventive Health Care, COVID-19—coronavirus disease 2019.
*Grading based on the CTFPHC.

**Box 3. Information sources**

COVID-19 practice guidelines
- Public Health Agency of Canada COVID-19 guidance for the public and practitioners: **https://www.canada.ca/en/public-health.html**
- CDC COVID-19 patient information in various languages: **https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/communication-toolkit.html**
- Smith JA, de Dieu Basabose J, Brockett M, Browne DT, Shamon S, Stephenson M. Family medicine with refugee newcomers during the COVID-19 pandemic. *J Am Board Fam Med* 2021;34(Suppl):S210-6: **https://www.jabfm.org/content/34/Supplement/S210.full**
- *COVID19 recommendations and gateway to contextualization*[15]: **https://covid19.recmap.org/**

Refugee health practice guidelines
- Pottie K, Greenaway C, Feightner J, Welch V, Swinkels H, Rashid M, et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ* 2011;183(12):E824-925[9]: **https://www.cmaj.ca/content/183/12/E824**
- Canadian Collaboration for Immigrant and Refugee Health—refugee health e-learning, prevention e-checklist, and narrative podcasts: **https://ccirhken.ca/ccirh_main/**
- Multicultural Mental Health Resource Centre: **https://multiculturalmentalhealth.ca/**
- Caring for Kids New to Canada: **https://www.kidsnewtocanada.ca**
- *Trauma-informed: the Trauma Toolkit*[16]: **https://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf**

Social and income insecurity resources
- Upstream Lab: **https://upstreamlab.org/covid19/**
- Prosper Canada Financial Relief Navigator: **https://prospercanada.org/Resources/Online-Tools.aspx**
- 211: **https://211.ca/**
- National Newcomer Navigation Network: **https://www.newcomernavigation.ca/en/index.aspx**
- CLEAR Toolkit: **https://www.mcgill.ca/clear/**

CDC—Centers for Disease Control and Prevention, COVID-19—coronavirus disease 2019.

**Table 1. Examples of innovations to address structural inequities among refugee patients from across Canada**

| CHALLENGE | INNOVATION |
|---|---|
| COVID-19 prevention | • Promotion of evidence-based, culturally and linguistically relevant COVID-19 health information and public health recommendations using existing resources (**Box 3**)[9,15,16]<br>• Provision of QR codes to allow patients to quickly download commonly used health information onto their cell phones in their language of choice[17]<br>• Engagement with local language radio stations and encouragement of messaging from faith groups and other community leaders to address fears and stigma around getting tested*<br>• Development of voluntary spaces for people to safely isolate away from other family members, if required, with higher priority for vulnerable populations†<br>• For new arrivals who must quarantine, development of new safe spaces (eg, Welcome House in Halifax, NS, where food is delivered, garbage is picked up, and laundry service is arranged. Further, initial health screening and orientation are done virtually) |
| Access to COVID-19 testing | • Provision of transportation to testing centres for populations that would otherwise require public transit (Nova Scotia, provincewide)<br>• Engagement of health navigators to assist contacting centres to book appointments*<br>• Establishment of mobile testing models and "pop-up" testing sites where required‡<br>• Organization of taxi services booked by the settlement agency (Reception House in Kitchener, Ont)<br>• Advocacy for at-home testing options by public health or other in-home care providers§ |
| Access to COVID-19 vaccination | • Development of multilingual vaccine information webinars involving trusted health professionals launching community vaccine pop-up clinics without prejudice to insurance status in collaboration with public health†<br>• Prioritization of essential workers for vaccination (eg, meat-processing workers*)<br>• Provision of walk-in vaccination appointments for those who cannot access Web-based booking systems‖<br>• Support for tailored education, including multilingual fact sheets about questions related to vaccines, in collaboration with community partners in shelters and congregate settings where newcomers are residing‡<br>• Offer of vaccines in trusted community spaces, at convenient hours close to where people live and work‡<br>• Provision of a toll-free telephone number for patients to call to have their questions and concerns about COVID-19 vaccines answered in their first language, with health navigators helping patients book appointments at mass vaccination sites, and provision of transportation assistance, if needed* |
| Supporting women, children, and families | • Identification of families who may have difficulties connecting to care and making efforts to reach out with telephone medical interpretation to assess family situations and offer support to manage stressors‖<br>• Maintenance of availability of contraceptive options for women of childbearing age, consistent with SOGC pandemic guidelines[18]<br>• Provision of information and strategies with mobile apps to prevent and manage stress and mental health symptoms of pregnant and postpartum women[19,20] |
| Addressing stress and mental health | • Advocacy for equal compensation for virtual and in-person psychotherapy¶<br>• Connecting patients to virtual support groups and online mental health and stress management resources‡<br>• Outdoor group programs in the summer for adults, including support for child care, facilitated by mental health navigators in collaboration with community partners to promote safe social connection and support ongoing therapy* |
| Virtual care | • Provision of tablets for new arrivals to engage virtually*†<br>• Provision of donated cell phones and links to low-cost data plans, where needed‡ |
| Improving access to health services | • Provision of safe spaces for in-person visits for vulnerable populations. Large families, coming together for intake physical examinations or immunizations, are brought directly into examination rooms together to wait, minimizing exposure to others†<br>• Enhanced COVID-19 clinic screening using translated written and audio versions of screening questionnaires†<br>• Engagement of clinic staff to book laboratory appointments for patients¶ or the provision of in-house phlebotomy services*† |
| Identifying social needs and linking to resources | • Weekly e-mails highlighting government and community resources to address social stressors (eg, income supports, online training programs) (Toronto Local Immigration Partnerships in Ontario)<br>• Collaboration with community and settlement agencies to provide wraparound social support to reduce isolation. Toll-free telephone number connecting patients with their own community cultural broker for needs assessment and appropriate referrals*<br>• Creation of living electronic platforms with resource lists in multiple languages, as prepared by community organization networks# |
| Interpretation | • Shift from in-person to videoconferencing services such that interpreters appear on the computer screens at the local refugee clinic†¶ (local interpretive services)<br>• Advocacy for broader use of professional telephone interpreters across medical institutions†‡ |

CLSC—centre local de services communautaires, COVID-19—coronavirus disease 2019, REACH—Refugee Engagement and Community Health, SOGC—Society of Obstetricians and Gynaecologists of Canada.
*Mosaic Refugee Health Clinic in Calgary, Alta.
†Centre for Family Medicine Refugee Health Clinic in Kitchener, Ont.
‡Crossroads Clinic at Women's College Hospital in Toronto, Ont.
§REACH Clinic in Saskatoon, Sask.
‖Bruyère Family Medicine Refugee Clinic in Ottawa, Ont.
¶Newcomer Health Clinic in Halifax, NS.
#CLSC Parc-Extension in Montreal, Que.[21]

periods of mandatory self-isolation or quarantine for newly arrived refugees by assisting with medical needs through virtual care and through partnerships with settlement organizations to address social needs.

***Promote access to COVID-19 testing, care, and immunization.*** Even with lower testing rates among refugees and other migrants, secondary data analysis has found disproportionately high COVID-19 infection rates.[4] Exposure risks related to work, housing, and public transportation are compounded by a variety of barriers to testing. As well, varying levels of trust in health care institutions, often rooted in past and recent experiences of discrimination, exclusion, and systemic racism, may also hinder access to care.[22] Indeed, compared with Canadian-born residents, 3.2-fold fewer foreign-born residents obtain access to comprehensive primary health care.[23] Our experience also suggests health care providers can help patients to overcome barriers, including assisting with booking tests and arranging transport to testing locations. Further advocacy is required to ensure testing is truly accessible in priority communities by addressing this range of barriers. Additionally, it is important that vulnerable patients who have positive test results for COVID-19, or who otherwise require isolation, receive wraparound support and links to community resources to enable their safe isolation, with measures ranging from virtual clinical support to food deliveries to income support.

Increasingly, trusted primary care providers, alongside community members and community leaders, are helping provide information and answer questions about COVID-19 vaccine recommendations.[15] Moreover, linked database studies suggest refugees and migrants must be considered among priority groups for COVID-19 vaccines.[4,24]

***Support women, children, and families.*** Historically, through economic, environmental, and epidemiologic crises, women have borne a disproportionate burden of detrimental impacts.[25] Lockdowns and self-isolation measures for COVID-19 have deepened pre-existing inequalities and vulnerabilities in social, political, and economic systems[26] when, globally, women already earn less, have greater job insecurity, and have a greater likelihood of being informally employed.[27] As with Canadian-born families, family tension may mount in this context, coupled with loss of community contacts, and evidence-based guidelines remind us to be alert to domestic violence in any population.[9,26] Within Canada, refugee women who generally provide essential care for families, often also must work in front-line jobs that increase their risk of exposure to COVID-19.

Refugee children often excel in their host neighbourhood school environment, learning local languages and cultures and making new friends. Social integration of refugee children early in the resettlement period is critical for their well-being.[28] Our clinical experience has shown that, for a variety of reasons, some refugee families have elected to keep their children home for virtual learning, rather than attending in-person classes. Virtual environments lack many of the social and academic supports of in-person schooling, and therefore clinicians should discuss school attendance with appropriate public health prevention measures, and can play a role in alleviating many parental concerns. They can also advocate for appropriate technology, language, and cultural support for children and families to enable their participation in educational activities.

***Address stress and mental health.*** A large proportion of refugees have faced forced migration, precarious isolation, substandard living conditions, and limited health care during deadly epidemics in refugee camps. Layered onto pre-existing trauma and a multitude of post-migratory stressors, the COVID-19 pandemic has brought about further loss of access to settlement services, loss of employment and income, and prolonged social isolation, each of which exacerbates mental strain.[6,9] Primary care providers report frequent concerns of headaches, vision problems, and requests for sick notes and disability among patients, signaling underlying mental distress.[11] Sleep, anxiety, and mood have worsened for many, as individuals may have had more time to reflect upon and re-experience their past trauma without the distractions of daily life to help provide structure. Clinicians must remain alert for depression and anxiety and ensure a range of care options and platforms are available and responsive to patient needs and priorities[9] (for some, virtual care may facilitate access to care, whereas for others, in-person appointments may be a critical form of support). Health care providers can also help patients connect to available social and community programs to address underlying social and economic stressors.[29]

From a trauma-informed, strengths-based approach, clinicians can support patients in focusing on their lived experience, learnings, abilities, internal resources, and resilience in overcoming challenges (see *Trauma-informed: the Trauma Toolkit*).[16,30,31]

***Recognize the potential, but also the limitations of virtual care with refugees.*** In the face of COVID-19, primary health care and mental health services dramatically shifted to virtual care. Limitations, including technologic barriers, communication challenges, and privacy concerns,[32] make these services less accessible to many refugee patients. Most virtual platforms require patients to have laptops, cell phones with data plans, or access to Wi-Fi, and the digital and health literacy to navigate complex systems.

High-quality interpretation services are critical for health care delivery and should be considered a right when there is language discordance between providers and patients.[33] With increased reliance on an accurate

history, virtual care is also highlighting the foundational role of professional interpretation in providing safe, equitable care. Ideally, clinicians should integrate interpreters into virtual platforms and employ in-person and telephone interpretation when desirable and accessible. Experience shows that clinicians can advocate for their patients to gain access to the appropriate technology to facilitate virtual care and for platforms designed for those with limited digital literacy and proficiency in English or French. Furthermore, safe options for in-person care must remain available, given these barriers to virtual care.

***Stay alert to particular social needs, advocate for individual needs and system-level change, and encourage return to community and resettlement programs.*** Refugees often need support to connect to essential legal and social services, such as housing, language classes, and employment training, as well as for food security. Health providers should remain vigilant for signs of unmet social needs, such as housing instability and income insecurity,[19] explored in a sensitive, nonjudgmental way, and documented in patients' electronic medical records to ensure ongoing follow-up. Although many familiar social and settlement supports have been curtailed owing to pandemic restrictions, clinicians can help link refugees to community and resettlement programs as they become available, including in new virtual forms. A recent systematic review on homeless migrants[19] suggests screening for safety in the home and navigating and advocating for local social supports are essential components of care, guided by the priorities of patients themselves.[29]

## Case resolutions

***Case 1.*** Teams can address the unmet social needs of Mrs G., such as housing instability and unemployment, through links to social support services, while providing her daughter with virtual interpretation services, transportation assistance, and navigational assistance to support appointment booking. As well, you should sensitively explore the reasons Mrs G. may have had difficulty connecting with your clinic and collaboratively strategize how to address these access barriers to support ongoing care for her and her daughters.

***Case 2.*** Mr N. is hesitant to seek health care, as he had faced years of stigma and discrimination in his country of origin. You can reassure him that he is welcome and can feel safe in his new "medical home"—your clinic. You and your team can support him to navigate booking systems for COVID-19 testing and connect him to resources to reduce isolation, such as free food deliveries and available income support. You can direct him toward evidence-based Internet information sources and reinforce preventive health behaviour. Further, Mr N.'s hesitancy toward COVID-19 testing seems related to his immigration status and fears of recrimination at work. As his primary care provider, you can provide Mr N. with linguistically relevant information about his privacy and rights to get tested for COVID-19 and assure him that his immigration and employment status is independent of a COVID-19 diagnosis.

## Conclusion

The COVID-19 pandemic is amplifying structural inequities, and one culturally and linguistically diverse group—refugees and newcomers—is among the special populations that need effective and case-by-case care, support, and advocacy at this time. This article outlines practical COVID-19–appropriate interventions for refugee care and some concrete examples of advocacy for refugee patients.

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All authors contributed to the literature review and interpretation, and to preparing the manuscript for submission.

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