# Family Medicine with Refugee Newcomers During the COVID-19 Crisis

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**Abstract**

Certain members of society are disproportionately affected by the COVID-19 crisis and the added strain being placed on already overextended healthcare systems. In this article, we focus on refugee newcomers. We outline vulnerabilities refugee newcomers face in the context of COVID-19, including barriers to accessing healthcare services, disproportionate rates of mental health concerns, financial constraints, racism, and higher likelihoods of living in relatively higher density and multigenerational dwellings. Additionally, we describe the response to COVID-19 by a community-based refugee primary health center in Ontario, Canada. This includes how the clinic has initially responded to the crisis as well as recommendations for providing services to refugee newcomers as the COVID-19 crisis evolves. Recommendations include: (1) considering social determinants of health in the new context of COVID-19; (2) providing services through a trauma-informed lens; (3) increasing focus on continuity of health and mental health care; and (4) mobilization of International Medical Graduates for triaging patients based on COVID-19 symptoms; and (5) diversifying communication efforts to educate refugees about COVID-19.

*Keywords:* COVID-19; Refugee; family medicine; trauma-informed care; culturally and linguistically appropriate care.

## Family Medicine with Refugees During the COVID-19 Crisis

Amidst the evolving COVID-19 crisis, healthcare systems are being pushed beyond their capacities and access to healthcare is of growing concern across communities and nations. These challenges are significant for all citizens, as the crisis threatens the timely and adequate provision of care to those affected and those who are most vulnerable. Additionally, there are many who are disproportionately affected by the profound disruption in accessing services in the context of pre-existing experiences of marginalization and trauma. In this article, we specifically outline some of the vulnerabilities of refugee newcomers (which may also apply to other vulnerable groups), while sharing the initial experiences of a general practice devoted to community-based healthcare for refugee newcomers in a mid-sized urban setting in Ontario, Canada. The purpose of this article is to provide an illustrative example for other family health teams and public health organizations who serve refugee newcomers during the ongoing fight against COVID-19.

## Challenges for Refugee Newcomers During COVID-19

Like other vulnerable groups, refugee newcomers are particularly affected during the COVID-19 pandemic due to the exacerbation of factors that already hinder their access to the healthcare services. Barriers include lack of linguistically and culturally appropriate/sensitive care, low socioeconomic status (SES), and fear of accessing care.[1,2,3] Additionally, refugees experience disproportionately higher rates of mental health concerns due to their exposure to pre-migration traumas.[4,5,6] During the COVID-19 crisis, the capacity of healthcare systems to address these barriers and provide care sensitive to linguistically and culturally diverse patients is reduced as emergency measures increasingly take priority.

Low SES poses a significant barrier to accessing healthcare.[7,8,9] For people living in countries without universal healthcare coverage (like the United States), the costs of accessing

treatment and healthcare insurance can be insurmountable. In countries that provide universal healthcare coverage (like Canada), there are transitional periods during which newcomers are ineligible for health insurance. Beyond the direct costs of healthcare, individuals and families may also deal with challenges related to transportation to and from healthcare facilities, especially those who live in rural communities or other areas not serviced by public transit.

In the context of COVID-19, prohibiting the presence of family members or trusted friends during appointments can be an important deterrent due to patients' perceived sense of safety or other cultural factors, such as the importance of receiving same sex care, or other assumptions about the role of medical professionals.[10] Beyond cultural reasons, fears related to concerns about being denied services or being sent back to one's country of origin if they seek help can also lead refugees to avoid accessing care, even when desperately needed.[11] Such fears are particularly notable for refugees without healthcare insurance and those who are undocumented or without legal status. Further, refugee newcomers may be uniquely affected by COVID-19 due to the relatively higher rates of mental health concerns related to their experiences of forced displacement and pre-migration exposure to trauma (war, torture, persecution, and other human rights abuses).[4,5,6] Refugee newcomers' mental health concerns are likely to be compounded by the heightened levels of collective and individual anxiety and uncertainty during this time. Moreover, anxieties about seeking emergency services in a healthcare system that is already viewed as inaccessible, biased, or stigmatizing can add to peoples' distress—not to mention without in-person support from trusted family or friends. Other factors include limited interpretation services, limited help in understanding and navigating the healthcare systems, and delays in processing claims for asylum and applications for benefits.

These challenges are exacerbated for patients who are responsible for children or child patients who are navigating care with adult caregivers encumbered by psychosocial stress.[12,13]

Describing the provision of care for immigrants in the Bronx, New York during COVID-19, Ross et al. (2020) added numerous challenges to the myriad factors disrupting care for newcomers, including reduced use of bedside or in-person interpreters (including family members) and difficulties with conveying empathy and making a human connection through masks.[13] The authors also noted that immigrants are disproportionately affected due to their susceptibility to misinformation (particularly those with limited English language proficiency), increased likelihood to have employment deemed essential (requiring in-person work), and tendency to live in multigenerational households, where shared spaces (such as bathrooms) precludes social distancing and isolation if someone becomes sick. While not explicitly discussed, these challenges are certainly relevant to refugee newcomers.

Of course, many of the aforementioned barriers may be experienced to some extent by other marginalized groups (e.g., immigrant, visible minorities, Indigenous, and homeless community members).[9,15,16] That being said, tendency for these factors to aggregate and combine within-persons suggests that particular attention to the experience of refugee newcomers is warranted. Indeed, the perspective of amalgamating and exacerbating risk factors is commensurate with the perspectives of intersectionality[17,18] and cumulative risk,[19,20] whereby single health risks in isolation convey little harm, while many combined risks convey great harm. At the best of times, these barriers pose challenges to refugee newcomers' access to care, though there are many healthcare professionals who do their best to accommodate their patients' needs. It is important to note that this article is focused on the experience of refugee newcomers in suburban and urban contexts. Presently, we do not cover the experiences of the millions of

refugees residing in camps around the world, who are at additional risk due to ethno-religious and political reasons, the dense concentration of displaced people, and the severe lack of resources.[21]

## Waterloo Region (Ontario, Canada) and Sanctuary Refugee Health Centre

Consistent with research on the social determinants of health amongst refugee newcomers, a 2019 study of 1,090 immigrants ($N$ = 339 refugees) living in Waterloo Region found that newcomers experience language (44%), lack of sufficient information (25%), lack of knowledge of services (47%), high cost of services (14%), and unfriendly staff (8%) as barriers to accessing services.[22] Additionally, refugees in Waterloo Region are more likely than other immigrants to have five or more people living (39% versus 27%) and two or more generations living in one household (73% versus 61%).[22] Moreover, 60% of refugees reported a household income of less than $30,000.[22] In this context, Sanctuary Refugee Health Centre (Sanctuary) operates as a not-for-profit primary care clinic and hub for health and mental health services solely for refugee newcomers in Kitchener-Waterloo, Ontario. Sanctuary strives to provide culturally sensitive, trauma-informed, and appropriate services for refugees.[23]

As of May 2020, Sanctuary provides healthcare services for more than 5000 registered patients with more than 1000 individuals on the waiting list—all of whom came to Canada as refugees. Sanctuary's patients identify 84 different countries of origin and 77 different first languages, the most common of which are Arabic, Tigrinya, Spanish, Somali, and Turkish. Consistent with previous research on the physical and mental health of refugees,[2] the majority of Sanctuary's patients come from settings with a high burden of tuberculosis and other underlying medical conditions (e.g., heart disease, hypertension, diabetes, chronic respiratory diseases, cancer) as consequences of hardships and traumatic situations they endured before, during, and

post-migration (high burden countries, refugee camps, etc.). Their chronic health conditions heighten their risk for serious complications arising from COVID-19.

Among Sanctuary's patients, 45.3% are under 20, compared to 23% of Ontario's population; and only 3.1% are 65+, compared to 16.7% of Ontario's population. Given the age profile, added risk comes from the fact that Sanctuary's patients are proportionally more likely to be ambulatory carriers of the COVID-19 virus. Emerging evidence shows that, while younger people who contract COVID-19 have a lower mortality rate, they are still vulnerable to contracting the virus and are thus vital in the fight to reduce the spread.[24] Further, the fact that refugee newcomers are likely to live in more populated and multigenerational dwellings presents concerns regarding the adherence to social distancing policies and the potential for increased rates of exposure for Sanctuary's older patients.

Consistent with the younger demographic, the Sanctuary clinic has a high birth rate. Based on the number of Sanctuary's pregnant patients, more than 350 births are projected for the 2020 calendar year. This is of particular concern at the clinic, given the uncertainty regarding potential long-term consequences and transmissibility if pregnant women contract COVID-19. Notwithstanding these important risk factors, it is important to simultaneously acknowledge the many strengths and resilience factors of many refugee newcomers in relation to the COVID-19 crisis. These may be related to past experiences of dealing with disease, conflict, disaster, and social disruption in their homelands and other countries through which they have journeyed on their pursuit of refuge.[25] For example, research has shown that refugee women tend to have a lower crude birth rate, infant mortality rate, maternal mortality rate, and percentage of low birth weight than women in both their host country and their country of origin.[26]

Sanctuary has always been committed to making services accessible to refugees, even when they are not covered by health insurance. While most sponsored refugees will come under the Interim Federal Health Program (IFH)[27] on arrival for the first year, some must apply for coverage. Eligibility for coverage from the Ontario Health Insurance Plan requires residence in Ontario for a minimum of three months and that too involves completion of an application form.[28] For those refugees seeking asylum, their access to health coverage and social services depends on their preliminary claim being accepted, which can take up to three weeks. Sanctuary has provided care for refugee newcomers during this waiting period at no cost or has facilitated their access to care from other providers as a charitable organization. For example, Sanctuary cared for a pregnant woman who showed up at Sanctuary in acute crisis, septic with a malaria flareup, three days after arriving in Canada. Despite the woman's lack of health insurance and her not being a patient of the clinic upon arrival, Sanctuary was able to quickly triage her, facilitate her admission to hospital, coordinate her care with the hospital's infectious disease and antenatal care programs and, with the help of Sanctuary's volunteers, provide childcare at the clinic for the woman's young children for the four days she was in the hospital. Notably, Ontario has temporarily suspended the three-month requirement during the COVID-19 pandemic.[28]

**How Sanctuary has Responded to COVID-19**

The number of patients seeking care in the clinic dropped by approximately 50% in the days following the Government of Ontario's declaration of a state of emergency on March 17.[29] The decrease is important for reducing the spread of COVID-19 and has been facilitated by the Province of Ontario releasing new temporary physician billing codes for telehealth services.[30] However, this presents its own set of challenges, with regard to trauma-informed, patient-centered care for families with diverse cultural and linguistic backgrounds. Sanctuary has

implemented a number of measures to continue services and to maintain a safe environment for staff and patients. Sanctuary has cancelled all non-essential clinic activities and has adopted Ontario's billing codes for telemedicine. Where possible, appointments are conducted over the phone or video and interpretation is provided when needed. Efforts are made to serve patients' needs remotely and to see a patient in person only after a provider has had a virtual consult. To facilitate this, Sanctuary staff now phone each patient who has an appointment early in morning, triage problems and complaints, and establish a time for a virtual consultation. They advise patients to stay at home in the interim and call immediate attention to a service provider when there might be an emergency. Walk-ins of patients who do not have appointments have been a longstanding challenge and there are those who seek help in person regardless of the advice given. Patients in distress are appropriately screened at the entrance and escorted to an isolation room for further examination if showing symptoms of COVID-19. Administrative staff are working remotely and most volunteers, especially those who are older, are taking vacation.

Beyond these relatively standard measures, the emerging crisis has led to the following recommendations for providing services to refugee newcomers during the COVID-19 crisis: (1) consider social determinants of health; (2) provide services through a trauma-informed lens; (3) increase focus on continuity of health and mental health care; (4) mobilize support from International Medical Graduates; and (5) diversify communication efforts.

***Consider social determinants of health***

Economic insecurity, racism, stigma, problems related to documentation, employment, interpersonal and relationship distress, domestic violence, child abuse, and related challenges are likely to be exacerbated in times of crisis.[31,32] Thus, it is particularly important to continue to pay attention to these social determinants of health for refugee newcomer patients in the context of

the COVID-19 pandemic. Having open communication about patients' situations and how COVID-19 has affected their socioeconomic circumstances and social and familial relationships can provide important insight into the factors that may be affecting their health status. Asking relevant questions can demonstrate caring and removes the onus of initiating the disclosure of challenges from the patient. It can also enable the patient to share information that can inform a discussion about potential resources and additional supports that might be available to them in their community.

***Provide services through a trauma-informed lens***

The provision of services through a trauma-informed lens is an important consideration for providing care to refugees. Trauma-informed care ensures that services foster a sense of safety, security, and trust and that the services are informed by the patient's history of trauma. This is particularly critical during COVID-19 due to the fact that the conditions and emergency policies may resemble those from which they fled in their home countries and may thereby pose risk of retraumatization.[33] Unfortunately, the emerging crisis challenges the culture of welcome and safety that is so important to staff and patients alike. To overcome issues of mistrust and perceived lack of safety, the staff at Sanctuary dedicate a substantial amount of time to developing trusting relationships with their patients, including taking time to listen to the patient and get a thorough understanding of their past and current experiences and needs and ensure that the patient retains a sense of control and involvement in decisions about their care.

***Increase focus on continuity of health and mental health care***

Lockdowns and infections may worsen the emotional situation of refugee patients. Many community programs that normally support refugee newcomers, such as food banks, shelters, children's camps, language classes, sports activities, and community gatherings have been

cancelled. The overarching crisis, coupled with resultant economic stressors, closures of important community programs, and social isolation may influence other aspects of health, personal care, and interpersonal relationships in addition to compliance with COVID-19 preventative efforts. It is recommended that, whenever possible, people with preexisting health and mental health conditions should continue with their treatment and be aware of new or worsening symptoms.[34] Telephone and video interventions can include brief assessment and motivational interviewing around mental health strategies during the state-of-emergency as well as full therapy sessions. Virtual platforms can enable the continuation of care while minimizing in-person appointments, though challenges related to technological skills and interpretation services and costs are certainly a barrier. It is also important to be mindful of technological access barriers. For example, it is often the case that newcomers do not have a landline or mobile plan but can connect via other online platforms that comply with privacy standards. In some cases, in order to access patients virtually, use of platforms that are not compliant with the jurisdictional health information protection acts may be necessary as a first step to provide telemedicine for virtually hard-to-reach patients.

***Mobilize support from International Medical Graduates***

During COVID-19, Sanctuary has used the expertise of two International Medical Graduates (one nurse and one physician) to triage patients over the phone. Sanctuary has been able to redeploy the help of one internationally trained physician and nurse from administrative positions, which they had filled while working to acquire Canadian credentials for practice. These individuals triage the nature and expressed urgency of a patient's problems based on federal guidelines[35] and make a referral to Public Health if patients exhibit COVID-19 symptoms. They have language skills, cultural sensitivity, and medical backgrounds that enable

them to respond with patience and empathy to each patient seeking an appointment over the phone.

***Diversify communication efforts***

Many refugee newcomers do not have linguistic competence in the vernacular, making it difficult or impossible to read and understand official information and announcements with regard to reducing the spread of COVID-19. Graphics and translations of official correspondence can help ameliorate this challenge. The UN Regional Risk Communication and Community Engagement Working Group[36] has recommended diversifying communication tools and format, simplifying messages, and testing messages with refugees. Accordingly, Sanctuary has produced educational materials with basic public health and prevention guidelines regarding COVID-19 in the most common languages (see supplemental materials). As of April 11, 2020, materials have been made available in English, Spanish, Turkish, Arabic, Tigrinya, and Amharic. Sanctuary has posted the materials at various locations onsite and on Sanctuary's website.

## Conclusion

The rapid spread of COVID-19 has led to tremendous difficulty for healthcare providers across the world. While all citizens are at risk, refugee newcomers have a unique constellation of risk and protective factors that must be considered to ensure the appropriate provision of primary care during the COVID-19 crisis, in addition to the delivery, access, and uptake of all health and social services. These challenges are sweeping and cut across layers of organization in the healthcare system, from primary care services, to emergency, intensive, and tertiary care, to public health initiatives and global prevention efforts. To support the wellbeing of refugees in the midst of the COVID-19 crisis, it is critical for healthcare service providers and practice briefings to adhere to principles of trauma-informed, linguistically tailored, and culturally sensitive

healthcare. In the coming weeks and months, these principles will become increasingly important, in addition to considerations regarding the management of existing medical problems and prevention efforts for other, long-term conditions interacting with COVID-19 related illness. We remain hopeful and optimistic for these goals, as the response from medical and allied health professionals has been nothing short of remarkable.

## References


1. Hadgkiss EJ, Renzaho AM. The physical health status, service utilisation and barriers to accessing care for asylum seekers residing in the community: A systematic review of the literature. *Aust Health Rev*. 2014;38(2):142–59. doi:10.1071/AH13113
2. Mangrio E, Forss KS. Refugees' experiences of healthcare in the host country: a scoping review. *BMC Health Services Research*. 2017; 17(1). doi:10.1186/s12913-017-2731-0
3. McKeary M, Newbold B. Barriers to care: The challenges for Canadian refugees and their health care providers. *Journal of Refugee Studies*. 2010;23(4):523–45. doi:10.1093/jrs/feq038
4. Porter M, Haslam N. Predisplacement and Postdisplacement Factors Associated with Mental Health of Refugees and Internally Displaced Persons. *JAMA*. 2005;294(5): 602. doi:10.1001/jama.294.5.602
5. Silove D, Ventevogel P, Rees S. The contemporary refugee crisis: An overview of mental health challenges. *World Psychiatry*. 2017;16(2):130–139. doi: 10.1002/wps.20438
6. Kien C, Sommer I, Faustmann A, et al. Prevalence of mental disorders in young refugees and asylum seekers in European Countries: a systematic review. *Eur Child Adolesc Psychiatry*. 2019;28(10):1295-1310. doi:10.1007/s00787-018-1215-z
7. Williamson DL, Stewart MJ, Hayward K, Letourneau N, Mak-warimba E, Masuda J, et al. Low-income Canadians' experiences with health-related services: implications for health care reform. *Health Policy.* 2006;76:106–21. doi:10.1016/j.healthpol.2005.05.005
8. Stewart MJ, Neufeld A, Harrison M, Spitzer D, Hughes K, Makwarimba E. Immigrant women family caregivers in Canada: implications for policies and programmes in health and social sectors. *Health Soc Care Community.* 2006;14:329–40. doi:10.1111/j.1365-

2524.2006.00627.x

9. Ahmed S, Shommu NS, Rumana N, Barron GRS, Wicklum S, Turin TC. Barriers to Access of Primary Healthcare by Immigrant Populations in Canada: A Literature Review. *J Immigr Minor Heal*. 2016;18(6):1522-1540. doi:10.1007/s10903-015-0276-z
10. Morris MD, Popper ST, Rodwell TC, Brodine SK, Brouwer KC. Healthcare barriers of refugees post-resettlement. *J Community Health*. 2009;34(6):529-538. doi:10.1007/s10900-009-9175-3
11. Khullar D, Chokshi DA. Challenges for immigrant health in the USA—the road to crisis. *Lancet*. 2019;393(10186):2168-2174. doi:10.1016/S0140-6736(19)30035-2
12. Browne DT, Kumar A, Puente-Duran S, Georgiades K, Leckie G, Jenkins J. Emotional problems among recent immigrants and parenting status: Findings from a national longitudinal study of immigrants in Canada. *Plos One*. 2017;12(4). doi:10.1371/journal.pone.0175023
13. Browne DT, Wade M, Prime H, Jenkins JM. School readiness amongst urban Canadian families: Risk profiles and family mediation. *Journal of Educational Psychology*. 2018;110(1):133-146. doi:10.1037/edu0000202
14. Ross J., Diaz CM., Starrels JL. The Disproportionate Burden of COVID-19 for Immigrants in the Bronx, New York. *JAMA Internal Medicine.* 2020. doi:10.1001/jamainternmed.2020.2131.
15. Marrone S. Understanding barriers to health care: a review of disparities in health care services among indigenous populations. *Int J Circumpolar Health*. 2007;66(3):188-198. doi:10.3402/ijch.v66i3.18254
16. Ramsay N, Hossain R, Moore M, Milo M, Brown A. Health Care While Homeless:

Barriers, Facilitators, and the Lived Experiences of Homeless Individuals Accessing Health Care in a Canadian Regional Municipality. *Qual Health Res*. 2019;29(13):1839-1849. doi:10.1177/1049732319829434

17. Viruell-Fuentes EA, Miranda PY, Abdulrahim S. More than culture: Structural racism, intersectionality theory, and immigrant health. *Social Science & Medicine.* 2012;75(12):2099–2106. doi:10.1016/j.socscimed.2011.12.037
18. Gkiouleka A, Huijts T, Beckfield J, Bambra C. Understanding the micro and macro politics of health: Inequalities, intersectionality & institutions - A research agenda. *Social Science and Medicine*. 2018;200(January):92–98. doi:10.1016/j.socscimed.2018.01.025
19. Evans GW, Li D, Whipple SS. Cumulative risk and child development. *Psychological Bulletin*. 2013;139(6):1342-1396. doi:10.1037/a0031808
20. Zhang J, Savla J, Cheng HL. Cumulative Risk and Immigrant Youth's Health and Educational Achievement: Mediating Effects of Inter- and Intra-Familial Social Capital. *Youth and Society*. 2019;51(6):793-813. doi:10.1177/0044118X17717501
21. Aid workers brace for impact of coronavirus in refugee camps. cbc.ca. https://www.cbc.ca/news/world/aid-workers-brace-for-impact-of-coronavirus-in-refugee-camps-1.5506172. Published Mar 23, 2020. Accessed Mar 23, 2020.
22. Immigration Partnership of Waterloo Region. *Immigration Matters Survey 2019: Full Report.* DOCS#3140974. 2019. https://www.immigrationwaterlooregion.ca/en/resources/Surveys/Immigration-Matters-Survey-Report-2019.pdf.
23. [Masked for Blind Review]
24. Centre for Disease Control and Prevention (CDC). Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) - United States, February 12–March 16,

2020. *MMWR Morb Mortal Wkly Rep. ePub*. March 18 2020. doi:10.15585/mmwr.mm6912e2

25. Masten AS, Narayan AJ. Child development in the context of disaster, war and terrorism: Pathways of risk and resilience. *Annual Review of Psychology*. 2012;63:227–257. doi:10.1146/annurev-psych-120710-100356
26. Hynes M, Sheik M, Wilson HG, Spiegel P. Reproductive health indicators and outcomes among refugee and internally displaced persons in postemergency phase camps. *JAMA*. 2002;288(5):595–603. doi:10.1001/jama.288.5.595
27. Interim Federal Health Program: Summary of coverage. Canada.ca. https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/help-within-canada/health-care/interim-federal-health-program/coverage-summary.html. Updated December 2, 2019. Accessed May 20, 2020.
28. Apply for OHIP and get a health card. Ontario.ca. https://www.ontario.ca/page/apply-ohip-and-get-health-card. Updated April 3, 2010. Accessed May 20, 2010.
29. Ontario enacts declaration of emergency to protect the public: Significantly enhanced measures will help contain spread of COVID-19. Ontario.ca. https://news.ontario.ca/opo/en/2020/03/ontario-enacts-declaration-of-emergency-to-protect-the-public.html. Updated March 17, 2020. Accessed March 20, 2020.
30. OHIP Bulletin 11229: Primary care changes in response to Corona Virus (COVID-19) effective March 14, 2020. health.gov.on.ca. http://health.gov.on.ca/en/pro/programs/ohip/bulletins/11000/bul11229.pdf. Published March 16, 2020. Accessed March 20, 2020.
31. Lee D, Brooks-Gunn J, McLanahan SS, Notterman D, Garfinkel I. The Great Recession, genetic sensitivity, and maternal harsh parenting. *Proceedings of the National Academy*

*of Sciences*. 2013;110(34):13780-4. doi:10.1073/pnas.1312398110

32. Schneider W, Waldfogel J, Brooks-Gunn J. The Great Recession and risk for child abuse and neglect. *Child Youth Serv Rev*. 2017;72:71–81. doi:10.1016/j.childyouth.2016.10.016
33. Júnior JG, de Sales JP, Moreira MM, Pinheiro WR, Lima CKT, Neto MLR. A crisis within the crisis: The mental health situation of refugees in the world during the 2019 coronavirus (2019-nCoV) outbreak. *Psychiatry Res*. 2020;288:113000. doi:10.1016/j.psychres.2020.113000
34. Mental Health and Coping During COVID-19. Centers for Disease Control and Prevention. https://www.cdc.gov/coronavirus/2019-ncov/prepare/managing-stress-anxiety.html. Published March 14, 2020. Accessed March 24, 2020.
35. Interim national surveillance guidelines for human infection with Coronavirus Disease (COVID-19). Canada.ca. https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/interim-guidance-surveillance-human-infection.html. Updated February 10, 2020. Accessed March 21, 2020.
36. UN Regional Risk Communication and Community Engagement Working Group. COVID-19: How to include marginalized and vulnerable people in risk communication and community engagement. March 19, 2020. https://interagencystandingcommittee.org/covid-19-how-include-marginalized-and-vulnerable-people-risk-communication-and-community-engagement. Accessed March 20, 2020.