

Immigrants' and refugees' experiences of access to health and social services during the COVID-19 pandemic in Toronto, Canada

Journal of Health Services Research & Policy
2022, Vol. 0(0) 1–8
© The Author(s) 2022



Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/13558196221109148
journals.sagepub.com/home/hsr



Doris Leung¹ , Charlotte Lee², Angel He Wang² and Sepali Guruge²

Abstract

Objective: In 2020, the World Health Organization reported that immigrants were the most vulnerable to contracting COVID, due to a confluence of personal and structural barriers. This study explored how immigrants and refugees experienced access to health and social services during the first wave of COVID-19 in Toronto, Canada.

Methods: This study analyzed secondary data from a qualitative study that was conducted between May and September 2020 in Toronto that involved semi-structured interviews with 72 immigrants and refugees from 21 different countries. The secondary data analysis was informed by critical realism.

Results: The vast majority of participants experienced fear and anxiety during the COVID-19 outbreak but through a combination of self-reliance and community support came to terms with the realities of the pandemic. Some even found the lifestyle changes engendered by the pandemic a positive experience.

Conclusions: Self-reliance may hinder help-seeking and augment the threat of COVID-19. This is particularly a concern for the most vulnerable immigrants, who experience multiple disruptions in their health care, have limited material resources and social supports, and perhaps are still dealing with the challenges of settling in the new country.

Keywords

immigrants, refugees, COVID-19, Canada

Introduction

On 11 March 2020 the World Health Organization declared COVID-19 a global pandemic.¹ By 17 June 2021, there were 176,693,988 confirmed cases and 3,830,304 confirmed deaths around the world.² Of these deaths, 26,001 were in Canada.³ During the first wave of COVID-19, the Canadian death rate peaked by mid-April 2020 at 194 deaths in one day.³

During the first wave of COVID-19, racialized immigrants and refugees throughout the world experienced higher rates of underlying medical conditions (e.g., diabetes, hypertension, and obesity⁵) placing them at higher risk for COVID-19 infection.^{4,5} Moreover, in the US and UK, Black, Asian, and Latino immigrants were more likely to die of COVID-19, as compared to their white counterparts, even after adjusting for age and underlying comorbidity.⁵ By December 2020, the World Health Organization reported that immigrants and refugees were the most vulnerable to contract COVID-19, due to limited

access to information in their language and to more likely live in large, multigenerational families or with multiple roommates, coupled with medical, economic, and legal structures that marginalized them.⁵

Compared with the other G7 nations (France, Germany, Italy, Japan, the UK, and the US), Canada had the highest rate of growth of its immigrant population between 2018 and 2019 (a 1.4% increase).⁶ In 2019, Canada welcomed 341,180 immigrants as permanent residents and

¹School of Nursing, The Hong Kong Polytechnic University, Kowloon, Hong Kong

²Daphne Cockwell School of Nursing, Toronto Metropolitan University, Canada

Corresponding author:

Sepali Guruge, The Daphne Cockwell Health Sciences Complex, Toronto Metropolitan University, Room DCC-579C, 288 Church St, Toronto, OA M5B 2K3, Canada.

Email: sguruge@ryerson.ca

resettled 30,087 refugees.⁶ Immigrants to Canada mostly originated from India, China, the Philippines, Nigeria, and Pakistan.⁶

In 2019, 45% of new immigrants (including refugees) to Canada chose Toronto as their new home, making it the most popular city of choice for immigrants.⁷ During the pandemic, Toronto neighborhoods with the highest ($\geq 25\%$) proportion of racialized individuals reported age-standardized mortality rates of 35% from COVID-19 as compared to neighborhoods with the lowest proportion (less than 1%) of racialized individuals, which had 26% mortality rates.⁸ By May 2020, Public Health Ontario reported that Toronto's most ethnically and racially diverse neighborhoods were more negatively affected by COVID-19 than its less diverse neighborhoods. For instance, hospitalization and intensive care unit admission rates in these neighborhoods were four times higher and death rates were twice as high as the citywide average.⁹ For this study, immigrants were defined as persons who chose to settle permanently in another country.¹⁰ In our case, we took as a new immigrant someone who had moved to Canada within the past 5 years. Refugees were defined as persons who were forced to leave their home countries due to persecution.¹⁰

Immigration is characterized by processes that construct and organize classifications of persons qualified to enter a country.¹¹ It is a social structure designed to meet countries' cultural, economic, and social objectives.¹² Immigrants are admitted to Canada through four social structures: as educated skilled workers (58% of all immigrants in 2019), via family members' sponsorship (27% in 2019), for protection as a refugee (14% in 2019), and for humanitarian reasons (1% in 2019).¹² Hence, the majority of immigrants are highly educated, screened medically thus in good health with the exception of refugees.¹³ The majority of new immigrants are healthier than resident Canadians.¹³ However, the incumbent population may perceive immigrants as needing considerable health care upon their arrival.¹³ This provides evidence that the process of acculturation, as a social structure, is set in motion prior to entry to the country, and that how one enters Canada, combined with unknown mechanisms of how one accesses health insurance and health literacy, shape migrants' health outcomes.¹⁴

Studies demonstrate evidence of persistent disadvantage for racial minorities and immigrants based on their immigrant status, race, and gender both in Canada's labor market and in the healthcare system.^{11,13} In particular, in a synthesis of 102 studies about refugees in Canada during the first wave of COVID-19, Edmonds and Flahault¹⁴ found that refugees were more likely to encounter barriers to accessing health care, due to limited economic support, border crossing impediments, and lack of access to education and social support. In other words, whether refugees encountered health care barriers was not solely determined by

immigration policies, but individual factors such as an individual's capacity to access health and social resources.

During the COVID-19 pandemic, public health policies appeared to set into motion factors that likely exacerbated difficulties faced by immigrants, such as Asians, who experienced stigmatization (i.e., negative social labeling).¹⁵ A study involving members of the Chinese community in Toronto during the COVID-19 pandemic found that while some Chinese reported being the target of racism, other Chinese could not tell if people were physically avoiding them due to race-based stigma or because they were simply following public health protocols.¹⁶

Social structures condition but do not necessarily determine individual behavior, as one has causal powers over one's own actions, or collectively through others' actions.^{17,18} As Elder-Vass states, "human action may be affected by social causes without being fully determined by them."^{17(p87)}

The purpose of this article is to understand the experiences of immigrants and refugees of their access to healthcare and social services during the COVID pandemic. The research question was as follows: What are immigrants and refugees' experience of accessing healthcare and social services in Toronto, Canada, during the first wave of COVID-19?

Method

We used secondary data based on semi-structured interviews that were conducted from May to September 2020 (the first wave of COVID-19 in Canada). Study participants were recruited through word of mouth, email, social media, and advertisements from community partners, who work with immigrants. Three criteria were used to purposefully select adult participants (18 years or over): (i) self-identify as immigrants or refugees and (ii) reside in apartment complexes in the Toronto or the Greater Toronto Area, (as the primary research question theorized social distancing was most challenging when individuals had limited social capital). Interviews were conducted by phone, Zoom, or Skype (audio only) in their preferred language (e.g., English, Urdu, Spanish, Korean, Arabic, Mandarin, and Tamil). Each interview lasted five to 46 min with an average length of 17 min.

Using a short questionnaire, key demographic information was collected, followed by a semi-structured interview. Prompts were used as appropriate to gain depth of understanding. Digital voice recorders recorded the data for transcription. The original text was then translated into English for analysis. Data analysis was aligned to interpretive description. Verification was conducted by a research assistant. The research team of the former study deemed that sampling saturation had been reached when no

recurrent themes occurred.¹⁹ This happened after approximately 72 interviews.

In the current study, we chose critical realism to guide the data analysis because of its potential to reveal mechanisms and structures about how a social phenomenon may occur.¹⁷ This paradigm combines objective as well as subjective data to go beyond casual description and uncover causal explanation.¹⁸ Critical realism assumes multiple determinants of causality linked in multifaceted ways with social inequalities, through an interplay between social structure and individual agency.^{17,18} More details on our qualitative paradigm of critical realism are given in an [online Supplement S1](#).

Data analysis drawing on critical realism¹⁷ was primarily inductive, and followed four levels of abstraction. First, comprehension of data occurred through chunking data and labeling them in codes that reflected participants' experiences. Specifically, we asked several questions: (a) How did it happen? (b) Why did it happen? (c) For whom did it happen? (d) Under what circumstances did it happen? Independent coding of the first 10 transcripts by two researchers, followed by conversations to reach consensus between the researchers, helped to build the initial coding structure. This coding structure was then used by the lead author to code further interviews. After each set, any new codes identified were discussed with a second research team member.

Second, after the initial coding structure was developed, synthesis of the codes was carried out through an iterative process with at least one other research team member to build, refine and confirm codes. This process allowed patterns to be determined under possible subthemes.

Third, theorizing moved through an inferential process using analytical devices of critical realism, that is, abduction, retroduction, and retrodiction.¹⁷ Abduction refers to early inferential reasoning that may best explain a pattern. Retroduction refers to inferences of the constituent prerequisites (i.e., relatively enduring mechanisms and structure) for generating patterns. These were used to make deductive inferences that were then explored inductively with the data to establish credibility. These inferences were used as the building blocks to explain how events or experiences were actualized. Next, retrodiction was used to identify how these events and experiences interacted to produce and affect each other forming epistemic patterns of mechanisms and structures.¹⁷ This process continued until all interviews were analyzed and preliminary findings and data saturation was determined.

Fourth, peer debriefing with the whole research team was done in order to identify, develop, and re-conceptualize subthemes and themes. Data were managed using NVivo12.¹⁹

Several techniques were used to establish rigor: credibility, plausibility, transferability, and utility.²⁰ Specifically,

the lead author kept an audit trail of analysis (i.e., theoretical memos) and was responsible for analysis of all interviews, while a second research team member supported independent coding for the initial coding scheme and subsequent confirmation of all new codes. Credibility of codes was established through dialogue to reach consensus with the lead author. In addition, the other members of the research team followed up by examining the whole analytic process and the plausibility of all identified patterns. In this process, all divergent opinions were resolved through active discussion. Lastly, raw data exemplifying research interpretations are displayed in this article for readers to judge utility and transferability of the findings to their contexts and clinical practice. Authors followed a checklist of Standards of Reporting Qualitative Research to ensure transparency and comprehensiveness.²¹

All four co-authors identify as racialized individuals, and are nurses with qualitative research experience. In addition, all identify as being part of an immigrant family in Canada, hence all have a vested interest in the research topic of immigration and access to health care. The lead author was experienced in the approach of critical realism and led analysis, while other team members drew on their expertise in researching immigrant health and health services to support analytical confirmation and data abstraction. The Principal Investigator of the study (the last author) also has extensive experience working with immigrant groups in Toronto.

Ethical considerations

Ethics approval of the original study, including secondary data analysis, was obtained through the respective Research Ethics Board of the participating university. Confidentiality of participants' identities was ensured through redaction of identifiable information during transcription and prior to data analysis. Further, data were password-protected on researchers' computers, and virtual hard drives. In this article, participants are only identifiable through numbers that were assigned to them upon recruitment to avoid potential identification.

Results

Our results represent interviews with 72 participants from 21 countries and speaking 19 languages: Arabic, Bengali, Cantonese, English, Farsi, Filipino, Hindi, Ibo, Korean, Malayalam, Mandarin, Punjabi, Roma, Russian, Spanish, Tagalog, Tamil, Turkish, and Urdu. Three participants declined to answer socio-demographic questions. Following is a summary of the demographic information of the remaining 69 participants: 51 women and 18 men; mean age = 41.8 years; 70% had children who lived with them; 24% lived with extended family; 56% had immigrated to

Canada more than 11 years ago; 5% were new immigrants; and 68% were not in paid work. More detailed characteristics of the participants are given in [online Supplement S2](#).

Although the majority of participants were Canadian citizens and not recent immigrants, most appeared to have a strong sense of reliance on their own local and ethnic communities, rather than broader social structures. This was likely due to a heightened sense of concern for their health and safety in their families and local communities,²² and impacted by perceived discrimination reported in social media (prior to and during the COVID-19 pandemic).^{16,23}

Self-reliance and conforming to public health guidelines

The vast majority of participants expressed a self-reliant ability to conform to public health guidelines and/or to build capacity and resources to mitigate the threat of COVID-19. For example, some reported that they gave up paid work and others stated that they stocked up on personal protective equipment like surgical masks and gloves. More than half of participants expressed knowledge of and access to material resources to help respond to COVID-19. For instance, they had private transportation, successfully applied for financial subsidies, and had knowledge of disease prevention. Moreover, they reported taking extra precautions to be safe at home and in social situations. This included doing extra work to plan where and how they conducted everyday chores of shopping, banking and exercising. One participant described their precautions:

With my family, since there is a lot of us, we take precautions in which [for example] every time someone gets home, we would wash our hands and sanitize, put their clothes right away in the laundry so that there won't be any cross-contamination, and things like that. (Participant 1530)

Immigrants' fear and anxiety about COVID-19

All the participants reported feeling fearful and anxious about contracting COVID-19 through undertaking everyday activities such as hugging family members, shopping, ordering take-out food, or traveling on public transport. One participant stated:

Even simple tasks like doing laundry requires me to go down to the basement of our apartment in the coin laundry room. When I go down to the basement, I am always thinking about the people that I will come in contact with. I always wear a mask. (Participant 1300)

Physical and emotional proximity with others dictated their level of anxiety. Their fear became pronounced when interacting with others at work or when seeking health services in person. One participant expressed these fears:

A PSW [personal support worker] is coming to give me a bath. There is some risk of COVID. But I could not help myself. So, I am at risk all the time. (Participant 1700)

When someone they knew contracted COVID-19, this escalated their anxiety about passing it on to a household member, particularly in the crowded spaces of their apartment building. For instance, one participant described their experiences living in a densely populated building:

Taking the elevator is a big worry. Also, living in such densely populated building is also a concern. In my condo, we had a security guard who tested positive. So, all of us were very scared. We were so scared that we don't want to go out at all. (Participant 2000)

Public health guidelines about COVID-19 raised participants' awareness of the dangers of old habits "Sometimes we forget and go close to others" (Participant 1000) and consciously led some to modify or stop these habits. This became more apparent when participants struggled to negotiate meeting their own needs while trying to avoid conflict or social awkwardness with others. As a result, fear about COVID-19 contagion generated new social norms "Attitudes of people changing...the respect is not there anymore. People want to stay away from you" (Participant 1257). This included some participants hesitating in deciding whether to access health care professionals for minor or chronic illnesses.

The pandemic disrupted health services (e.g., dentists and eye specialists) and wait times increased. As a result, just under half of the participants chose to wait until their or their dependents' illnesses were acute or prolonged before attempting to access health and social services. One parent of two sick children stated: "It was three entire weeks of not getting better before I brought them to see a doctor" (Participant 1400). The pandemic not only added scheduling challenges but added worry whether one would receive a proper diagnosis and/or treatment communicating by phone or online platforms. One participant stated:

In the beginning, even when I was in severe pain, I avoided seeing a doctor. All we could do is to consult him online and he will prescribe medicine on the phone. Though in my situation, physical examination is very important to pinpoint the new pain spots and treat them accordingly. (Participant 1800)

As public health restrictions were prolonged, this added another level of uncertainty, increasing participants' fear

and anxiety, particularly for those worried about the consequences for dependents (e.g., restricted finances, loss of education, and fear of traveling abroad). This was particularly the case for family caregivers who worried about how their dependents would cope if they, as caregivers, became ill:

When my baby used to get sick, my friends or close relatives who are living close to me used to come to me to help me. Now if I face the same situation, they would not be able to come to me. What would I do that time? Because me and my husband are both first-generation immigrants, when I think of this kind of situation, I feel very lonely here. (Participant 1100)

The importance of social networks

All participants relied on their close social network to help them access information (e.g., on obtaining financial subsidies or health knowledge), personal protective equipment (e.g., masks and gloves) and other forms of support. Sometimes, emotional support came from friends and family abroad:

It's really good because [of] my family back home in the Philippines. We're more connected as of now because of COVID. Like, what's going on there and what's going on here. We compare what's happening. (Participant 1300)

While public health guidelines may have led to a sense of isolation, participants became more conscious of how grateful they were for the companionship and resources extended to them by family and friends. This also helped them to recognize how important these relationships are and encouraged participants to maintain and protect them: "Now, it is a great chance to spend more time with my daughter" (Participant 1000).

Very few participants reported that there were protocols in place at work to protect them from COVID-19 or that they could obtain information in their preferred language. Approximately one third of participants relied on established or credible trusted resources, such as immigrant chat rooms, government websites for financial subsidies, community food donations, and health care providers:

When my doctor told me about the virus, then I started paying attention to it. I didn't know before. I don't read the news. So, after my doctor told me about this virus, I started looking into it. (Participant 1003)

But this was not always the case. For about a third of participants, resources (such as personal protective equipment or food delivery) were inaccessible or unavailable

because participants did not know about them or resources were constrained:

I know at least in the beginning it was very tough to find masks and it was next to impossible to find hand sanitizer. I do find it more common now, but it is still difficult to find exactly what you need, and I think increasing the supply would be good step to take for the government. (Participant 1700)

In addition, a few participants expressed a reliance on spiritual structures of faith or religion:

Other than that, all I can do is to pray to Allah that he protects us from this pandemic and we come out of this safe and sound. (Participant 1509)

Tolerating everyday COVID-19 disruptions

All participants tended to accept the COVID-19 situation and tolerated the changes it imposed. Participants were resigned to the inconveniences they encountered in everyday tasks (like long queues for shopping and banking, and inconvenient hours visiting pharmacies), mail service disruptions and limited leisure activities. However, many participants expressed discontent with the technology and reduced frequency of learning and social contact (e.g., Zoom, WeChat, WhatsApp, or Facebook). As one student said:

Not being able to meet with friends and the most difficult part is the online learning. The teachers are using different platforms to deliver the lessons and it's so confusing. (Participant 1659)

But a few participants preferred the new social norms, appreciating the additional time they had which could be spent with family in their households or in developing new skills. More than half of the participants enjoyed the time and money they were saving due to restrictions on social gatherings and travel (local and abroad):

It can be convenient and inconvenient at the same time. Although we have to wait a bit outside of [department store] Costco to get in, once we get in there are fewer people... There is less traffic on the road. I have gotten used to driving. I don't have to wait for the bus if I am driving to work. The total amount of commuting time is shorter. It's more convenient... With COVID-19, people are more cautious. The frequency of meetups decreased, but they still feel as intimate and lively. I actually prefer this. (Participant 2000)

Of concern, almost all participants described multiple disruptions in the supports and resources available to them, which augmented constraints to their access to health and social services. For instance, for the new immigrants, most

of the community health and social support services were temporarily closed:

When I arrived, it was very challenging to try to settle in, and I was applying for work and this COVID thing happened and makes things difficult. All of the networks I tried to start doing, I couldn't apply them. Quite challenging. (Participant 1515)

A small number of participants described difficulties learning about or accessing services to meet their needs. This included knowing how to do internet banking or finding information about COVID-19 guidelines in their language:

I tried multiple Korean immigrant resources. However, they were difficult to navigate...So, I have to do a lot of digging on my own...There is a lot of information that I could not find, even when I tried multiple times. (Participant 1300)

About 20% of participants had underlying disabilities or were older people with multiple medical conditions, such as mental health problems, diabetes, heart disease, and cancer. They found the disruptions to their social lives led to new physical or mental health problems or exacerbated existing issues. As one participant said of their mother:

She was so afraid. She didn't go outside for 56 days. She stayed at home. So, at the end, she got sick, and she was so nervous, so angry, so depressed. (Participant 1400).

Discussion

The vast majority of participants experienced fear and anxiety during the COVID-19 outbreak but through a combination of self-reliance and community support came to terms with the pandemic. Participants who developed a sense of connectedness and care from close social networks appeared better able to tolerate delays in accessing health and social services.

Participants tended to perceive they were at a higher risk of COVID-19 contagion due to their living in crowded apartments, having limited internet access, and limited English proficiency blocking their access to information and resources.²³ We suggest this situation may exacerbate their vulnerability to psychological or mental health problems, due to their propensity to be self-reliant or only seek help from close social networks. It is a concern that the public health policies during the first wave of the pandemic may not have paid particular attention to the concerns of and potentially higher risk faced by the individuals and the families living in apartment buildings.

Our study theoretically extends what may be posited about how immigrants in Canada and elsewhere may develop resiliency during COVID-19. Conformity to a norm of self-reliance is socially constructed,²⁴ and may mean

immigrants are less willing to access professional services for mental health problems. In our study, the vast majority of immigrants expressed multiple disruptions to essential services, which impacted their individual agency, including their employment, access to public health information, and access to health services for underlying medical conditions or disabilities. This led about a third of participants experiencing pronounced difficulties during public health restrictions imposed by the COVID-19 pandemic.

Specifically, we suggest that for those immigrants and refugees most vulnerable to restrictions imposed by the COVID-19 pandemic, a propensity for self-reliance may help reinforce a sense of resilience, but may hinder seeking professional mental health care when it is needed.²⁵⁻²⁷ This result aligns with a meta-analysis by Wong et al.,²⁸ who assessed the link between specific dimensions of conformity to masculine norms (e.g., self-reliance, emotional control, and power over women) and mental health-related outcomes. They found that for 19,453 participants self-identifying in five groups (African American, Asian American, Latino American, White American, and Multi-racial), conformity to socially specific masculine norms, such as self-reliance, consistently demonstrated associations with poorer mental health-related outcomes and a lower propensity to seek psychological help. Wong, et al. suggested that those "who are extremely self-reliant and emotionally controlled might potentially struggle with seeking help and developing intimate relationships with others."^{29(p10)} Our results suggest that safeguarding immigrants' and refugees' access to health and social services requires that culturally rooted self-reliance is tempered with access to professional health services.

There is a clear policy implication arising from our study. Rather than closing social services during pandemics,¹⁴ attention should be given to funding and keeping community services open, particularly psychological counseling and professional mental health resources (albeit in ways that are safe). According to Rothman, et al.,²⁹ many immigrants report no access to primary care physicians and heightened fears of contracting COVID-19, if having to go to emergency departments is their only viable option for healthcare. Further, immigrants may be more vulnerable to mental health stress due to COVID-19 lockdowns as a consequence of their propensity to be self-reliant.³⁰ Indeed, public health restrictions have contributed to essential workers, more often immigrants, being laid off, or to choosing to leave their employment, due to fears of exposing their family to the virus; as well as to immigrants worrying about family members left in their countries of origin.³⁰ Hence, we recommend that community services need to remain active in sharing knowledge, supporting immigrants and refugees, and reinforcing healthy degrees of self-reliance.

Limitations

This study has two main limitations. First, the sample size was relatively small, so no subgroup analysis based on ethnicity, socio-economic status, age, gender, or stage of participants' immigrant journey could be undertaken.

Second, the study was confined to one city in Canada. That means it does not represent the cultural diversity of Canadians living in other cities or regions or in smaller towns or rural communities.

Conclusion

This study examined the pivotal mechanism of self-reliance, which was used by the vast majority of study participants to regulate their fear and anxiety surrounding COVID-19 and to conform to public health guidelines. Further, immigrants' agency was strongly shaped by the quality of their close social supports, which protected them and minimized the need for health and social services. But self-reliance may hinder immigrants' propensity to seek help and may increase the threat of contracting COVID-19, generating more risk to mental health problems. This is of particular concern for the most vulnerable immigrants, who experience multiple disruptions in their health care, material resources and social supports during disease outbreaks, while at the same time are attempting to acculturate to a new country.

Acknowledgments

We would like to thank South Riverdale Community Health Centre for their assistance in the recruitment of participants.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Ethics approval

Ethics approval was obtained from the Ryerson Research Ethics Board (REB#2020–179).

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The Faculty of Community Services at Ryerson University provided funding. The funders did not play any role in data collection, interpretation or reporting of the study findings.

ORCID iD

Doris Leung  <https://orcid.org/0000-0002-9636-3118>

Supplemental Material

Supplemental material for this article is available online.

References

1. World Health Organization. *Migrants and refugees say COVID-19 has dramatically worsened their lives*, 2020, <https://www.who.int/news-room/feature-stories/detail/migrants-and-refugees-say-COVID-19-has-dramatically-worsened-their-lives> (accessed 22 April 2021).
2. World Health Organization. *Coronavirus disease (COVID-19) pandemic*, 2021, <https://www.who.int/emergencies/diseases/novel-coronavirus-2019> (accessed 17 June 2021).
3. Government of Canada. *COVID-19 daily epidemiology update*, 2021, <https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html?stat=num&measure=deaths&map=pt#a1> (accessed 7th July 2021).
4. World Health Organization. *Refugees and migrants in times of COVID-19: mapping trends of public health and migration policies and practices*, 2021. Licence: CC BY-NC-SA 3.0 IGO <https://apps.who.int/iris/rest/bitstreams/1351802/retrieve> (accessed 20 June 2021).
5. Clark E, Fredricks K, Woc-Colburn L, et al. Disproportionate impact of the COVID-19 pandemic on immigrant communities in the United States. *Plos Negl Trop Dis* 2020; 14: e0008484.
6. Government of Canada. *Annual report to parliament on immigration*, 2020, <https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/annual-report-parliament-immigration-2020.html> (accessed 7th July 2021).
7. Public Health Toronto. *TO health check: an overview of Toronto's population health status*, 2019, https://www.toronto.ca/wp-content/uploads/2019/11/92ef-TOHealthCheck_2019.pdf (accessed 20 March 2021).
8. Subedi R, Greenberg L and Turcotte M. *COVID-19 mortality rates in Canada's ethno-cultural neighborhoods*. *Statistics Canada*, 2020, <https://www150.statcan.gc.ca/n1/pub/45-28-0001/2020001/article/00079-eng.htm> (accessed 10 January 2021).
9. Public Health Ontario. *Enhanced epidemiological survey: COVID-19 in Ontario. A focus on diversity*, 2020, <https://www.publichealthontario.ca/-/media/documents/ncov/epi/2020/06/COVID-19COVID-epi-diversity.pdf?la=en> (accessed 11 March 2021).
10. Canadian Council for Refugees. *Talking about refugees and immigrants: A glossary of terms*, 2010, <https://ccrweb.ca/sites/ccrweb.ca/files/static> (accessed 5 April 2022).
11. Lightman N and Good Gingrich L. Measuring economic exclusion for racialized minorities, immigrants and women in Canada: results from 2000 and 2010. *J Poverty* 2018; 22: 398–420.
12. Cheatham A. *What is Canada's immigration policy? Council on foreign relations*, 2020, <https://www.cfr.org/background/what-canadas-immigration-policy> (accessed 14 February 2021).
13. Beiser M. The health of immigrants and refugees in Canada. *Can J Public Health* 2005; 96: S30–S44.

14. Edmonds J and Flahault A. Refugees in Canada during the first wave of the COVID-19 pandemic. *Int J Environ Res Public Health* 2021; 18: 947.
15. Han CS and Oliffe JL. Korean-Canadian immigrants' help-seeking and self-management of suicidal behaviours. *Can J Commun Ment Health* 2015; 34: 17–30.
16. Mamuji A, Rozdilsky J, Lee C, et al. *Expanding the narrative on anti-Chinese stigma during COVID-19: lessons on complexity & capacity in Toronto and Nairobi*. Centre for Human Rights, Equity and Inclusion, York University: Disaster & Emergency Management York University, 2020. Technical Report #005.
17. Elder-Vass D. *The causal powers of social structures: emergence, structures, and agency*. Cambridge, UK: Cambridge University Press, 2010.
18. Angus J, Miller K-L, Pulfer T, et al. Studying delays in breast cancer diagnosis and treatment: critical realism as a new foundation for inquiry. *Oncol Nurs Forum* 2006; 33: E62–E70.
19. QSR International Pty Ltd. (2020) NVivo (released in March 2020), <https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home>.
20. Elo S, Kääriäinen M, Kanste O, et al. Qualitative content analysis: A focus on trustworthiness. *SAGE Open* 2014; 4(1): 1–10.
21. O'Brien BC, Harris IB, Beckman TJ, et al. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med* 2014; 89: 1245–1251.
22. LaRochelle-Côté S and Uppal S. *The social and economic concerns of immigrants during the COVID-19 pandemic*. Statistics Canada, 2020. [online]: Available from. www150statcan.gc.ca/n1/en/pub/45-28-0001/2020001/article/00012-eng.pdf?st=0qIIZAXN
23. Greenaway C, Hargreaves S, Barkati S, et al. COVID-19: exposing and addressing health disparities among ethnic minorities and migrants. *J Trav Med* 2020; 27: 1–3.
24. Mo PKH, Mak WWS and Kwan CSY. Cultural change and Chinese immigrants' distress and help-seeking in Hong Kong. *J Ethn Cult Divers Soc Work* 2006; 15: 129–151.
25. Leung DY, Chan ACY and Ho GWK. Resilience of emerging adults after adverse childhood experiences: a qualitative systematic review. *Trauma Violence Abuse* 2020; 23: 163–181.
26. Han J, Batterham PJ, Callear AL, et al. Factors influencing professional help-seeking for suicidality. *Crisis* 2018; 39: 175–196.
27. Shi W, Shen Z, Wang S, et al. Barriers to professional mental health help-seeking among Chinese adults: a systematic review. *Front Psychiatry* 2020; 11: 442.
28. Wong YJ, Ho M-HR, Wang S-Y, et al. Meta-analyses of the relationship between conformity to masculine norms and mental health-related outcomes. *J Couns Psychol* 2017; 64: 80–93.
29. Rothman S, Gunturu S and Korenis P. The mental health impact of the COVID-19 epidemic on immigrants and racial and ethnic minorities. *QJM Monthly J Assoc Physicians* 2020; 113: 779–782.
30. Mia MA and Griffiths MD. Letter to the editor: the economic and mental health costs of COVID-19 to immigrants. *J Psychiatric Research* 2020; 128: 23–24.