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Impact of COVID-19 on Resettled Refugees



Micah Brickhill-Atkinson, Fern R. Hauck, MD, MS, FAAFP*

KEYWORDS

• COVID-19 • Refugees • Vulnerable populations • Health care access

KEY POINTS

- Refugees experience unique challenges during the COVID-19 pandemic, including suspension of resettlement.
- Other harms of COVID-19 that affect the population at large have intensified effects on refugees, such as economic and disease vulnerability, mental illness exacerbations, communication challenges, and educational disruption.
- The Society of Refugee Healthcare Providers published guidelines for assessing refugees' barriers to following COVID-19 preventive recommendations.
- Recent reports from refugee health care providers offer suggestions for mitigating pandemic-related harm, including communication, case management, and advocacy.

INTRODUCTION

The novel coronavirus SARS-CoV-2 (COVID-19) has infected nearly 13 million people and has caused more than 570,000 deaths globally.¹ As the pandemic creates new challenges for worldwide communities, the refugee crisis remains another of humanity's grave tragedies. Refugees displaced due to war, violence, and oppression number 21.3 million worldwide.² As of April 4, 2020, thirty-four countries with substantial refugee resettlement reported local COVID-19 transmission.³ Statistical data about the impact of COVID-19 on this population is scarce,⁴ but a growing body of literature reveals that bureaucracy, poverty, and discrimination have threatened the well-being of refugees during the pandemic.² COVID-19 has additionally highlighted barriers to accessing health care for refugees,⁵ who stand foremost among the world's most vulnerable people. The United Nations 2030 Agenda for Sustainable Development contains a promise to ensure no one is left behind,³ and COVID-19 will only be controlled when all populations are included in the response.⁵ Current literature

Department of Family Medicine, University of Virginia, PO Box 800729, Charlottesville, VA 22908-0729, USA

* Corresponding author.

E-mail address: frh8e@virginia.edu

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highlights 6 themes of the refugee pandemic experience (Table 1) and elucidates techniques for assessing barriers and alleviating harms.

SUSPENSION OF RESETTLEMENT AND RELATED SERVICES

Case 1: A.N. is a 30-year-old man from Afghanistan. He arrived in the United States 1 year ago. Soon after, his marriage to an Afghan woman was finalized, and he was assured that his wife would follow him to the United States. Now, he reports significant anxiety after his wife's migration was delayed due to COVID-19. The couple was informed that reunification would be deferred for at least 6 months.

Kathleen Newland of the Migration Policy Institute aptly pronounces, "COVID-19 has been the greatest disruption to human movement since World War II."⁶ On March 10, 2020, the International Organization for Migration and the United Nations High Commissioner for Refugees (UNHCR) suspended refugee resettlement in the wake of worldwide travel restrictions.⁷ The hold was lifted on June 18, 2020, after 10,000 refugee migrations were deferred. Some travel restrictions remain in place and continue to delay life-saving departures for persecuted people.⁸ In addition, downstream effects such as expiration of security checks and overseas health examinations postpone travel for months after the resumption of resettlement.⁹ Displaced persons are at risk of persecution in their countries of origin, and families face prolonged separation. Precedents from Ebola and SARS show that travel bans additionally incite stigma for migrant communities already in host countries.¹⁰ Suspensions tend to harm refugees without benefiting host countries because many migrants would travel from an unaffected country to a nation with already high case counts. According to a World Health Organization report in 2018, refugees are at a low risk of transferring communicable disease to the host population in general.⁷

Table 1 Impacts of COVID-19 on resettled and accepted refugees	
Suspension of Resettlement and Related Services	<ul style="list-style-type: none"> • Prolonged persecution • Delayed reunification • Expiration of security and health checks • Modified resettlement assistance after arrival
Economic Hardship	<ul style="list-style-type: none"> • Disproportionate job loss • Difficulty accessing relief • Reduced support for overseas family members
Disease Vulnerability	<ul style="list-style-type: none"> • Overcrowded living conditions • Comorbidities • High risk occupations • Delayed care and public health measures
Mental Illness Exacerbations	<ul style="list-style-type: none"> • Higher need • Memories of forced isolation and hiding • Modified and reduced mental health services
Communication Challenges	<ul style="list-style-type: none"> • Need for linguistically appropriate information • Barriers to virtual communication
Pediatric Impacts	<ul style="list-style-type: none"> • Boredom and loss of daily structure • School closings

Newly arrived refugees also face reduced volunteer and public services during the pandemic.⁷ Volunteers and staff may be quarantined or restricted by government mandates, which disturbs provision of resettlement resources.² For example, the International Rescue Committee (IRC) in Charlottesville, Virginia typically provides an orientation for refugees attending their first medical appointment. Staff members transport clients to the family medicine clinic and show them how to find the waiting room and register. COVID-19 restrictions do not allow such transportation or accompaniment, and refugees must navigate the unfamiliar health system alone (E. Uhlmann, MPH, personal communication, July 16, 2020).

ECONOMIC HARDSHIP

Case 2: M.K. is a 35-year-old single mother of four. She and her daughters arrived in the United States 2 years ago, and she began working as a hotel housekeeper. She lost her job during COVID-19 and has not found new employment. Her landlord comes to the apartment for rent, evoking tremendous anxiety. The family fears eviction as funds become scarce.

For resettled refugees, the impact of COVID-19 manifests in part through economic hardship. Migrant groups tend to fill difficult, low-paying occupations in their host countries.⁴ In a study of 8 nations that house more than one-third of the world's refugee population, refugees were 60% more likely to lose jobs or income due to COVID-19 than the local population. About 60% worked in the most affected occupations, such as food services and retail, compared with 37% of the host population.¹¹ Low-income households have less ability to work remotely, which creates increased susceptibility to job loss amid the pandemic.¹² Refugees often carry the additional burden of sending money to family in their country of origin, so pandemic-related economic hardship reaches even further than those immediately affected by job loss.⁶ Refugees also face barriers in accessing public services and safety nets. The Kovler Center Child Trauma Program (KCCTP), which serves refugee families in Chicago, recently noted that families frequently experienced job loss and struggled to access unemployment benefits.¹³

DISEASE VULNERABILITY

Case 3: N.D., her husband, and 5 children are refugees living in an apartment with 1 bathroom. Even prepandemic, sharing a bathroom caused problems such as constipation in one of the children due to withholding bowel movements. COVID-19 measures seem nearly impossible to the family in light of their crowded home.

COVID-19's disease burden is higher in low-income settings such as resettled refugee populations due to living conditions, comorbidities, high-risk jobs, and delayed care and public health measures. The London School of Hygiene and Tropical Medicine reports that large and multigenerational households are a major reason for the disproportionate impact.¹² Overcrowded housing confers an increased risk of contracting disease,⁷ and refugees often live in conditions that make hygiene and distancing impossible.⁵ Management of chronic illnesses, such as diabetes mellitus and human immunodeficiency virus (HIV), is especially challenging among refugee populations during the pandemic.¹⁴ Patients may be afraid to leave the house and may not be able to access prescriptions or appointments.

Endale and colleagues¹³ propose that refugees are disproportionately affected by COVID-19 due to the frequency of high-risk jobs. For example, a high proportion of African refugees in the United States fill nursing home caretaker roles, which places them in one of the most vulnerable settings.¹⁵ Low-income families are disincentivized from infection control measures, such as staying home from work, because their livelihoods are stretched too far.¹²

Refugees are vulnerable to stigma about disease transmission, which may make them fearful to disclose symptoms.¹⁵ They may also delay seeking care due to fears of contagion or loss of legal protection.¹⁰ In addition, widespread testing and contact tracing are less feasible in low-income settings; therefore, the current extent of disease is likely underestimated.¹²

MENTAL ILLNESS EXACERBATIONS

Case 4: S.A. is a 25-year-old female refugee with depression, anxiety, and posttraumatic stress disorder (PTSD) who presents to clinic with a chief concern of “stomach pain.” During the interview, she becomes tearful as she describes increased nightmares and feeling hopeless when she thinks of her family members still in her country of exit. She fears leaving her apartment and contracting COVID-19, which evokes memories of forced hiding in her childhood.

Mental health is a chief concern among refugees during both pre- and post-pandemic circumstances. Systematic reviews estimate prevalences of up to 44% for anxiety, 44% for depression, and 36% for PTSD.² Migrants are more vulnerable to mental health risks in pandemics than the host population.¹³ A 2020 literature review of international journals examined factors that worsen refugee mental health and found substantial commonality with risk factors for COVID-19.² Overlapping themes included overcrowding; disrupted sewage disposal; lower standards of hygiene; poor nutrition; reduced sanitation; and lack of shelter, health care, public services, and safety.² Boredom, isolation, inadequate supplies, lack of information, financial concerns, and disease-related stigma exacerbate the psychosocial effects of pandemics and quarantine.¹³ Isolation and lack of control, prominent conditions in the COVID-19 setting, are known to exacerbate PTSD. Memories of forced hiding may be evoked by lockdowns and empty streets, and the pandemic may be reminiscent of Ebola and cholera for African migrants.¹⁵

Host countries face overloaded mental health care at baseline, making them ill equipped to adequately care for the pandemic-induced exacerbations among refugees.² Community-based mental health resources have moved to remote operations, making access even more difficult.¹³ Baseline shortages combined with the exacerbating factors of a pandemic set up an environment for crisis among refugee mental health patients.

COMMUNICATION CHALLENGES

Case 5: D.N. is a 30-year-old female refugee from Afghanistan who recently arrived to the United States. She has a history of domestic abuse and fled her husband’s family with her 3 children. In the few months since her arrival, she presented to clinic four times with vague somatic concerns, anxiety, and depressed mood. She was offered telephone therapy, as the clinic had paused in-person counseling sessions due to the health system’s COVID-19 precautions. However, she is reluctant to share her traumatic experiences over the phone and reports little benefit from these sessions. She asks if she can instead participate in in-person therapy, where she would feel more comfortable discussing her trauma history.

Communication is a particular challenge for refugee patients in the pandemic setting. Lau and colleagues remind providers that communication is especially important for displaced populations who distrust authorities because of past experiences.¹⁰ One challenge arises in accessible information sharing. Refugees struggle to find culturally and linguistically appropriate data about COVID-19.⁷ Obstacles also present in the arena of telecommunication. The KCCTP noted the following barriers to refugee telemedicine: computer and Internet access; technological proficiency; attention span; decreased speed of interpretation; and privacy concerns.¹³ Shared living conditions and unstable housing make private virtual communication difficult for many families. Providers at the Boston Center for Refugee Health and Human Rights (BCRHHR) noted that patients were sometimes unwilling to share trauma or torture histories over phone or video.¹⁵ Although the host population may rely on virtual information sharing, refugees face added barriers in accessing these alternative communication modalities.

PEDIATRIC IMPACTS

Case 6: C.K. and M.K. are 7-year-old twins who arrived to the United States 1 year ago. In clinic, it is noted that they speak and understand little English. Their mother relates that they cannot read in any language. They do not speak English at home, and they did not attend school the past 4 months due to closings.

Pediatric refugees' daily functioning has suffered during COVID-19, attributable to boredom, isolation, and loss of daily structure.¹³ IRC Medical Case Manager Erica Uhlmann in Charlottesville, Virginia notes a pattern of refugee parents overprotecting their children and prohibiting them from going outside. The IRC and partnering medical providers are educating families that time outside is safe and healthy as long as social distance is maintained (E. Uhlmann, MPH, personal communication, July 16, 2020).

School closings detrimentally affect refugee children. A systematic review of factors influencing pediatric refugee mental health found that schooling is essential for their adaptation and positive mental health. A sense of belonging at school is associated with lower PTSD and higher self-esteem, whereas lack of school attendance correlates with externalizing behavior. Poor connectedness with a school increases risk of depression, anxiety, and somatic stress.¹⁶ Schools also provide a vital role in language acquisition for recently resettled children. Refugee students of all ages learn academic English in 4 to 7 years under ideal circumstances, but the interval increases to 10 years with interruptions to formal education. Schools maintain an indispensable role for educating migrant students and reducing achievement disparities.¹⁷ Although distance learning may be accessible for some students, limited technological proficiency among refugee families poses a barrier to remote schooling.¹³ The isolating conditions created by COVID-19 may have devastating impacts on pediatric refugee health and development.

TECHNIQUES TO ASSESS BARRIERS

The Society of Refugee Healthcare Providers issued guidelines to assess resettled refugees' barriers to following COVID-19 preventive behaviors. These include questions about fear of stigma or discrimination (eg, How have others in your community acted toward those who have become sick?); disease understanding (eg, Can you tell me

about the symptoms of COVID-19?); how the patient communicates with providers and accesses information (eg, Before the pandemic, how did you normally communicate with your health care provider?); difficulties with prevention recommendations (eg, Do you have face masks, soap, hand sanitizer, etc.?); barriers to health care (eg, Do you know where to go for COVID-19 testing?); and social support (eg, Is there someone you can call if you need assistance with groceries, medications, or other essential needs if you become sick?).¹⁸ The full assessment is available in **Box 1**.

TECHNIQUES TO MITIGATE HARMS

Refugee providers have published recommendations for reducing the harms of COVID-19. The BCRHHR issued the following suggestions: provide weekly email blasts about available community resources; watch for PTSD reemerging out of remission; remain mindful of patients' tolerance and attention span in telehealth sessions and consider shorter sessions if needed; maintain flexibility with in-person visits if patients are uncomfortable over the phone, especially patients who dissociate; and know the area's concrete food bank, unemployment, and shelter resources.¹⁵

The KCCTP offered the following resources to migrant families: exercise videos; guided relaxation and meditation; educational activities; caregiver guides; peer group video calls; virtual storybook readings; and cognitive behavioral therapy. The organization also initiated a response termed "Psychological First Aid." The approach started with information dissemination, dedicating attention to language accessibility. Next, providers turned their focus to active outreach, extensive case management, and telemedicine services.¹³ The University of Virginia International Family Medicine Clinic similarly prioritized information dissemination and mailed handouts from the Centers for Disease Control and Prevention (CDC) to families in their first languages (Fern R. Hauck, MD, MS, personal communication, July 21, 2020). Multilingual print resources from the CDC can be found at the following Web address: <https://www.cdc.gov/pubs/other-languages>. The UNHCR found that digital communication techniques are also useful for sharing information with refugees.²

Fawad and colleagues discuss the unique challenges of refugee chronic disease management in a pandemic.¹⁴ The 2009 H1N1 influenza outbreak demonstrated the need for contingency planning in chronic disease management; deaths from stroke, myocardial infarction, and acute heart failure increased in this epidemic setting. Providers may consider extended medication supplies, especially for heart disease, HIV, tuberculosis, and contraception.¹⁰

Policy-level mitigation can also help alleviate harms for refugees during COVID-19. For example, public health leaders in the United Kingdom call for temporary citizenship rights for all migrant groups.⁴ The UNHCR recommends full health care service access for refugees, reminding leaders that protecting all members ultimately shields the community at large.¹⁰ The Center for Global Development advocates for fast-track credentialing of refugees who could contribute to the nation's health response or assist with personal protective equipment manufacturing, contact tracing, and delivery services. Allocating COVID-19 relief money to local nongovernmental organizations is another strategy to meet refugee needs. Currently, only 0.07% of US COVID-19 relief funds reach these nonprofit agencies that have a record of effective local community service.¹¹

Local and national leaders, providers, and neighbors can also mitigate harm by maintaining a posture of openness and trust. Lessons from Ebola and SARS offer reminders that engaging communities and building trust contribute to the achievement of public health measures, whereas stigmatization opposes success. Transparency, trust, and community partnership are essential for disease control.¹⁰

Box 1**Society of Refugee Healthcare Providers Guide to Assessing Barriers to Following COVID-19 Prevention Guidance Among Resettled Refugees****Patient Communication**

1. Before the COVID-19 pandemic, how did you normally communicate with your health care provider?
2. Did you use an interpreter to communicate with your health care provider?
3. What is your preferred method of communication with health care providers? (eg, email, telephone, text messaging, mailed letter, direct provider interaction)
 - a. *If text message, mail, email, or telephone:* do you have anyone who can interpret (verbal) or translate (nonverbal, ie, documents) for you if needed? If so, is it a professional interpreter, community member, friend, or family member?
 - b. *If the interpreter was a community member, friend, or family:* have you felt fear or embarrassment when someone other than a professional interpreter was used to discuss health conditions?
4. How do you access information about COVID-19? (eg, Internet, television, newspaper, friends, social group, faith-based group, social media such as WhatsApp, TikTok)

Patient Understanding of COVID-19

1. Can you tell me about the symptoms of COVID-19?
2. Can you tell me about some health complications of COVID-19?
3. How do you protect yourself from getting sick with COVID-19?
4. How do you prevent family members and others from getting sick with COVID-19?
5. How would you normally treat *[list symptoms that are currently associated with COVID-19]:*
 - a. Fever?
 - b. Dry Cough?
 - c. Fatigue?
 - d. Headache?
 - e. Aches and pains?
 - f. Sore throat?
 - g. Chest pain?
 - h. Difficulty breathing or shortness of breath?

Fear of Stigma or Discrimination

1. Do you know anyone in your community who has either become sick with COVID-19 or tested positive for COVID-19?
2. How have others in your community acted toward those who have become sick?
3. Would you communicate with someone who was diagnosed with COVID-19? If so, how? When would you resume meeting the person face-to-face?

Barriers to Following COVID-19 Prevention Recommendations

1. Is there any person in your home who can help with household responsibilities if you were to become sick? *[this is primarily asked to persons living with others, such as adults and children].*
2. If someone in your house was to get sick with COVID-19, do you have a way to keep a six feet distance from other household members within your house?
3. Are you or anyone else in your household currently working?
 - a. If yes:
 - i. where are you/they working?
 - ii. what information has your/their employer provided?
 - iii. what steps have your/their employer taken to keep you and your family safe?
 - iv. If you or someone in your household were to become sick with COVID-19, do you think you would be able to miss work until you or your family member feel better and a medical professional said it was safe for you to go back to work?
 - b. If no one in the household is currently working, what support are you receiving financially?
4. Do you have access to:
 - a. Face masks and gloves?
 - b. Soap and/or hand sanitizer?

- c. Household cleaners and disinfectants?
- d. Enough dishware, eating utensils, clothes, towels, and bedding for sick and healthy family members?
- e. Essential needs such as a food, medications, and basic amenities (eg, electricity)?

Barriers to Health Care Access

1. Do you know where to go to receive testing for COVID-19? If yes, how did you find out about the testing site?
2. Do you know where to go to receive health care for COVID-19?
3. How would you get to a health care facility if you were sick and needed to see a health care provider?
4. Can you describe when you would feel you need to call 911? Are you comfortable calling 911?
5. Do you have health insurance that can help support your health care needs if you get sick?
6. Is there any reason that would prevent you from seeking care if you become sick?

Available Social Support

1. Is there someone you can call to support you (and/or your family) if you become sick? If you need to go to the emergency room?
2. Do you think this person can continue to assist you if you were diagnosed with COVID-19?
3. Is there someone you can call if you need assistance with groceries, medications, laundry and/or other essential needs while you are sick?
4. Do you think this person can continue to assist you if you were diagnosed with COVID-19?

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SUMMARY

The novel coronavirus SARS-CoV-2 poses singular challenges to the world's resettled refugee population. Suspension of resettlement prolongs suffering for refugees accepted but not yet relocated and delays family reunification, and modified resettlement agency operations create challenges for new arrivals. Refugees are particularly vulnerable to both economic hardship and severe disease in the wake of the pandemic. Mental illnesses, prevalent among this population at baseline, are exacerbated by isolative and uncertain conditions. Communication challenges make the virtual world less accessible to resettled refugees, and children suffer the consequences of boredom and loss of school resources. Refugee providers can mitigate harms by comprehensively assessing barriers faced by their patients, providing accessible information, and advocating for policies that include vulnerable populations and promote trust.

CLINICS CARE POINTS

- Implement questions from the Society for Refugee Healthcare Providers Guide to assess refugee patients' needs during the pandemic.
- Watch for PTSD reemergence and other mental illness exacerbations.
- Review local resources to enable concrete recommendations for refugees and all patients in need during the challenging pandemic conditions.
- Offer linguistically appropriate information about COVID-19 and preventive measures.

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The authors have nothing to disclose.

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