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The COVID-19 pandemic necessitated remote alternatives to in-person healthcare services for routine and emergent health conditions. Telehealth services, defined as healthcare services delivered remotely through telecommunications technology, increased exponentially during this time. Greater availability of telehealth options ensured compliance with stay-at-home orders mandated by local and state governments and offered a safe way for patients to seek medical care while containing the spread of COVID-19 infections. Local and federal governments around the world instituted regulatory changes while healthcare organizations invested in technological infrastructure to support the availability and uptake of telehealth services. Many of these changes are expected to outlast the COVID-19 pandemic making telehealth a viable option for healthcare delivery in the post-pandemic world.

While telehealth opened possibilities for remote access to healthcare, it also presented significant challenges for specific groups of people who were already vulnerable to healthcare disparities. Refugees and asylees constitute one such group. This narrative review discusses benefits of telehealth services for refugees and asylees, summarizes available data on telehealth challenges for this group, and identifies solutions to potential challenges to make telehealth services more accessible in countries of resettlement and asylum.

The Promise of Telehealth for Refugees and Asylees

Telehealth has been feasibly implemented with recently resettled refugees even prior to the COVID-19 pandemic. For example, an Australian study published in 2014 reported on the feasibility of a telehealth program where refugees resettled in rural areas worked with their local primary care doctors to consult remotely with infectious disease specialists at a regional tertiary care hospital. Despite some technical difficulties, the program was deemed feasible with added benefits of avoiding travel time and scheduling complications with patients. An additional advantage of the program was its positive environmental impact through minimizing travel with substantial savings in fuel consumption and CO₂ emissions per remote consultation.¹ Another Australian study published in 2015 examined the feasibility and acceptability of video-based remote interpreting during 50 outpatient clinical encounters of which a small number met the criteria for telehealth i.e. three-way clinical consultation with the doctor, patient and interpreter at separate locations. Other than minor technology glitches, the study found that telehealth consultations were acceptable for both

doctors and patients. These consultations were also deemed more feasible for accessing interpreters for uncommon languages spoken by refugee patients living in rural areas and for providing services outside of standard clinic hours.³⁰

Similar findings have been reported by studies involving refugee and asylee patients accessing telehealth services after the onset of the COVID-19 pandemic. A 2022 study based in Australia evaluated primary and specialty care telehealth consultations for refugees and asylum seekers. During the six-month study period, 3012 telehealth sessions were offered by phone of which 42% involved a language interpreter. Surveys and focus groups with patients and clinical providers (primary care doctors, nurses, psychologists and community health workers) found that despite clinicians' apprehensions about the efficacy of telephone mode of contact, patients were satisfied with the quality of care, ease of access, and reduced travel costs associated telehealth consultations. Clinical providers also reported improved healthcare access for patients with a history of missed appointments, those with mobility impairments, those who lived far from the clinic, those with caregiving responsibilities, and those in low security jobs that disallowed time off for healthcare appointments.²

Similar perceived benefits of telehealth consultations have also been reported in other studies involving refugee patients and refugee-serving clinical providers. For example, mental health providers surveyed at a US-based refugee-serving outpatient mental health clinic reported that telehealth sessions offered greater flexibility compared to in-person sessions, particularly for hard-to-reach patients and that in such cases, some mental health support, even if it was provided sub-optimally via telehealth sessions, was better than no healthcare at all.³

Some experts in refugee health believe that telehealth, which curtails travel and taking time off other tasks, and enables multiple healthcare appointments in a short period, might improve care coordination and thus be advantageous over in-person healthcare for refugees with complex health conditions.⁴ Telehealth can also widen service options for refugees and asylees, many of whom have emerging proficiency in the dominant language of the country they relocate to.⁵ For example, geographically dispersed refugees and asylees might be able to receive care from a central center that specializes in refugee services. In addition, medical opinions could be sought from remote experts and from bilingual providers in different regions, and even different resettlement countries.⁵ Finally, for refugees and asylees who face deep-seated stigma related to mental illness, telehealth offers a more inconspicuous means for accessing mental health services.⁶

Telehealth Pitfalls for Refugees and Asylees

Despite potential benefits, several challenges have been identified in delivery of telehealth services for refugees and asylees. These challenges include structural barriers, technological difficulties, problems with interpersonal communication, readiness of the healthcare provider, and patient skills and ability. See Table 1 for a summary of these barriers and related recommendations.

Structural Barriers: Lack of a private web-enabled device and a reliable Internet connection can hinder refugees and asylees from accessing telehealth services. Multiple sources including primary research studies, systematic reviews, expert commentaries, and reports have identified the digital divide as a significant structural barrier for this population, especially when telehealth services are offered through videoconferencing.^{3,6-10} Concerns about reliable digital access for refugees and asylees have been reported in multiple host countries including the United States, Canada, and Australia.^{3,6-8,10,11}

Precise statistics on refugees' and asylees' device ownership and Internet usage are lacking. However, much can be gleaned from available data on broader populations such as minoritized persons of color and foreign-born residents. A 2021 survey conducted with more than 1500 adults in the USA found that adults of Black or Latinx origin were significantly less likely than White adults to own a desktop or laptop computer or to have a broadband Internet connection at home.¹² While this digital divide can be partly explained by income differences between racial/ethnic groups, the role of immigrant status cannot be ruled out. For example, *within* the group of low-income Latinx households, 44% of those headed by immigrants reported not using a computer at all in 2016 compared with 19% of those who were US-born. Similarly, 10% of immigrant headed Latinx households had no Internet access in 2016 compared with 7% percent of U.S.-born Latinx families and 5% of White households.¹³

Evidence of a digital divide is also apparent from surveys conducted with immigrant and refugee newcomers in Toronto, one of the most diverse metropolitan areas in Canada. A 2020 survey with 95 newcomers found low rates of device ownership especially for respondents who completed the survey by phone. For example, 57% of phone respondents did not have access to a laptop and 37% did not have a smartphone compared with 28% and 16% respectively of online respondents. Some of the online respondents also reported that their smartphones were borrowed and had limited capability for accessing online services.¹⁴ Another survey in Toronto found that newcomers who had arrived in Canada in the past 10 years (44%) were more likely to be worried about paying for home internet than those born in Canada (31%).¹⁵

Taken together, available evidence suggests that for many refugees and asylees, particularly

those who are newcomers to their host country, suboptimal access to information technologies might hinder utilization of telehealth services. The literature recommends a few solutions around this structural barrier. For example, one systematic review found that telehealth uptake was smoother with patients from underserved racial/ethnic groups when patients were provided with videoconferencing equipment.⁷ A pilot study with 43 patients found that providing patients with donated tablets and assisting them with registration and set up was feasible and facilitated patient access to virtual health visits.⁹ Another study focusing on tele mental health found that some service agencies tried to support their clients by giving out device loaners such as donated phones and computers, and offering subsidies to purchase internet data plans.⁶

Educating patients about low-cost internet plans and/or connecting them with digital banks that offer used and refurbished equipment can also allay digital barriers. Another solution to work around the digital divide is for telehealth providers to change delivery modalities by offering telephone-based consultations where possible or by selecting videoconferencing software that requires less bandwidth, although this might mean forgoing ancillary features such as group video calling and screen sharing.^{2,4,6,10} When families share a single web-enabled device across multiple family members during the day, educational needs might be prioritized over healthcare needs. In such situations, the opportunity to make appointments after-hours or on weekends is recommended.^{4,6} Above all, there is a need for policy initiatives that leverage public investment in broadband infrastructure and subsidize access to information technologies for low-income and marginalized groups.¹¹

Patient Skills and Ability: Digital literacy skills are critical for patients' smooth and seamless utilization of telehealth services. Multiple studies have reported digital literacy, or lack thereof, as an important barrier to telehealth access for refugees and asylees.^{3,6-8} A trend noted across countries of resettlement and asylum is that foreign born individuals are disproportionately represented among those with lower digital literacy.¹³ For example, a 2015 study conducted by the Organization for Economic Cooperation and Development (OECD) found that compared with 36% of native-born residents, only 12% of immigrant residents in the United States reported high levels of proficiency in digital problem-solving.¹⁶ The same study found that 21% of non-English speaking immigrants in the United States reported no computer experience compared with 5% of English speakers.¹⁶

The above finding suggests that digital literacy is associated with proficiency in the dominant language in the destination country. While this association has been noted across high-income OECD countries with substantial immigrant populations, research examining this association in the context of telehealth has been mostly conducted in the United

States.¹³ Studies with broader immigrant samples including refugees and asylees have found lower rates of telehealth use among non-English speakers with limited or emerging English proficiency.¹⁷⁻¹⁹ The association between language proficiency and lower likelihood of telehealth use stands even after controlling for patients' health status, sociodemographic factors, and internet access.¹⁷ These findings were replicated in a study based on review of medical records at a family medicine clinic during the peak of the COVID-19 pandemic. The study found telehealth use to be lower among refugee patients, at 25%, compared with 39% for non-refugee patients matched for demographic factors, insurance status, health status, and visit timing. Moreover, language proficiency was found to be a strong predictor of telehealth use for refugee patients with 21% of refugee patients reporting adequate proficiency in English compared with 88% for non-refugee patients.⁴

It must be noted that proficiency in the dominant language of the destination country includes elements of both spoken ability and literacy skills, and both types of skills tend to be low among refugee and asylees. Based on data from the US Office of Refugee Resettlement, 8-18% of refugees report being able to speak English well or very well upon arrival. Similarly, objective assessment data collected by the Program for International Assessment of Adult Competencies indicates that about 28% of recent refugee arrivals in the United States have basic or higher levels of English literacy.²⁰ Although language proficiency is known to improve over time, these statistics, in light of previously cited research, suggest that language skills are important for telehealth uptake in this population.

In addition to language proficiency, level of education prior to resettlement/ asylum is also associated with digital skills and telehealth uptake. A survey study with 493 Bhutanese refugees resettled in the US found that respondents with no formal prior education or with education levels less than high school completion were less likely than those with higher education levels to report basic digital skills despite digital access. Respondents with basic digital skills were also more likely to engage in simple versus more complicated digital tasks. For instance, 83% reported using the internet to connect with family and friends but only 20% reported using the internet to access informational websites.²¹ Similarly, a regional resettlement agency in Canada found that digital literacy among recently settled refugees was limited to using instant-messaging apps and that less than 40% of recent arrivals had access to a computer.²² In the study with Bhutanese refugees, 73% of respondents reported never using telehealth services despite restrictions on in-person healthcare during the COVID-19 pandemic and despite high risk and incidence of cardiometabolic conditions that require routine medical consultation.²¹ These findings are indicative of 'fragmented digital knowledge' which refers to possession of digital skills that may allow performance of basic digital tasks but is insufficient for deeper digital problem-

solving skills. This type of fragmented knowledge is known to be higher among immigrant populations who have lower rates of computer ownership and high rates of smartphone dependence to access online information.

Several recommendations have been proposed in the literature to enhance or work around refugee patients' skills for better telehealth uptake and utilization. Most resettlement countries offer language training programs for recently arrived refugees and asylees. These programs could serve a dual purpose of enhancing language proficiency while also orienting learners to telehealth technologies and teaching digital literacy skills for telehealth utilization.¹¹ Bilingual community workers who are themselves formerly resettled refugees/asylees can be deployed to scale up language and digital skills training and support.⁸ Former refugees and asylees can also play the role of bilingual patient navigators to assist with virtual patient navigation and promote comfort with telehealth visits especially during the early resettlement period when patient skills are still in development. Benefits of virtual patient navigation are already well-established for other patient populations affected by the digital divide.²³

Technological Barriers: Technological barriers can impede telehealth use for all patients. However, some of these barriers are accentuated for refugee and asylee patients while others are unique to this population. In many advanced health systems, videoconferencing applications used for telehealth visits are integrated within the system's electronic health records (EHR) software. In such cases, patients are often required to enroll in a patient portal or secure website linked with the EHR software in order to schedule telehealth visits and access videoconferencing links.^{4,9} Enrollment in patient portals requires multiple steps including identity verification and accessing a secure code thereby creating technological complexity, especially for patients with limited digital literacy and emerging proficiency in the dominant language.^{9,24} One study involving retrospective analysis of electronic health records at a primary care clinic during the COVID-19 pandemic found that patient portal activation was much lower for refugee versus non-refugee patients (48% versus 65%). Further, patient portal activation significantly increased likelihood of telehealth use.⁴ Thus, requiring portal enrollment could be a barrier to telehealth use for refugee patients.

Setting up and authenticating a patient portal account also raises digital privacy concerns especially for refugee and asylee patients. In many countries of resettlement and asylum, it has been standard for federal authorities to extract data from phones and other electronic devices during the asylum process as strategy for verifying the asylum seeker's identity.²⁵ Some countries such as Great Britain plan to place electronic tagging devices on asylum seekers as a form of surveillance.²⁶ In the United States, asylum seekers and even bonafide

refugees share concerns about their personal information being reported to Immigration and Customs Enforcement.⁹ Privacy and safety concerns arising from such practices are understandable and can deter telehealth use among refugee and asylee patients if they are required to download videoconferencing applications on personal devices or need to register with virtual visit platforms.

Another barrier arises from lack of language accommodations within telehealth technologies. For example, instructions and prompts within patient portals use dominant languages such as English.⁹ In addition, patient portals and videoconferencing platforms lack features for seamless incorporation of language interpreters when needed.^{3,9} Given that many refugees and asylees have limited or emerging proficiency in the dominant language of the destination country, lack of language supports built into telehealth technologies can be a serious impediment.

As telehealth services continue to evolve, it is important that these technological barriers are minimized or resolved. Where possible, patient portal enrollment should not be made a necessary condition for availing telehealth appointments and patients must be made aware of this choice.⁴ Where patient portal enrollment is necessary for security reasons, patient education campaigns and navigation support can be offered to assist patients with the enrollment process. One health system in the United States successfully increased portal enrollment of patients with limited digital and language literacy by creating tip sheets and short videos in multiple languages on self-enrollment and launching virtual visits.⁹ Health promotion smartphones apps are also now available that integrate auto translation with additional support features including scheduling appointments, entering information in a patient portal, and preparing for medical visits.²⁷

Technological solutions are also available for better integration of language supports within telehealth systems. Some newer telehealth applications offer a seamless interface to preschedule language interpreters or add them to a videocall as needed.^{9,24} These applications can also be customized to send text messages in a patient's preferred language prompting them to join a virtual appointment by simply clicking on a secure link. Health systems may choose to add languages most commonly spoken by their patient population.⁹ Similarly, EHRs can also be customized to add an interpreter column to improve scheduling ease and enhance communication between language interpreters and clinicians.⁹

Finally, digital privacy concerns can be mitigated by using telehealth platforms that are browser based do not require downloading of a new application to the patient's personal device.⁹ In addition, health systems must avoid virtual visit calls where the caller

identification is hidden as patients might be reluctant to accept audio and videocalls from unidentified numbers.² Patient education resources that use infographics and lay language can also be created to reassure patients of steps being taken by the health system or clinic to protect their confidentiality.⁹

Communication Barriers: Telehealth visits whether by phone or videoconference are heavily reliant on direct communication between the patient and the clinical provider. On the other hand, refugee and asylee patients often hail from cultures that value communication styles steeped in context and non-verbal signals including gestures, body language, and facial expressions.²⁸ In such a scenario, communication barriers can be heightened especially with refugee and asylee patients due to the cross-cultural nature of visits.

In a US-based study, clinical providers surveyed at an outpatient mental health clinic serving refugee patients reported that telehealth appointments entailed verbal communication lags and constricted non-verbal communication thereby hindering trust and rapport building with patients.³ Similar communication difficulties were reported in interviews conducted with refugee patients and mental health providers across four Canadian provinces.⁶ Patients as well as newcomers believed that language barriers were compounded during telehealth visits and that expressing themselves was difficult in virtual settings. Loss of non-verbal communication, especially during phone-based telehealth visits, was deemed a potential source of misunderstanding.⁶ These concerns were also echoed by primary and specialty care providers interviewed at a refugee health and well-being clinic in Melbourne, Australia. Providers were especially concerned about communication barriers impeding comprehensive risk assessments and clinical decision making related to serious medical conditions.^{2,6} While some of these barriers could be mitigated by the presence of a language interpreter, the virtual environment also presented challenges for efficient and high-quality interpreting.^{2,6}

The literature suggests multiple solutions to address these communication barriers. First, involving qualified, well-trained interpreters is critical when patients and providers do not share a common language.²⁹ When interpreters are involved, it is important to carefully consider the modality of telehealth visits. It is generally recommended that interpreter-assisted telehealth visits be conducted via videoconference so that non-verbal cues and gestures can be used to aid interpreting.³⁰ However, some refugee patients might prefer phone interpreting for confidentiality reasons, therefore flexibility is important.³¹

Clinical providers can also use a variety of strategies to enhance communication during

telehealth visits with refugee and asylee patients. For example, an initial in-person meeting may be offered to new patients in order to build rapport before switching to telehealth appointments.^{3,7} Provider could also adopt communication strategies that are more effective for telehealth appointments such as paying greater attention to patients' verbal communication and voice tone, asking clarifying questions, verbally validating patient concerns instead of using facial expressions and gestures, and supplementing verbal instructions with infographics or other visual material.^{3,6,7}

Provider Skills and Readiness: Success of telehealth services largely depends on the skills, attitudes, and readiness of clinical providers. Though not specific to refugee/asylee patients, a study using EHRs from a large, urban healthcare system in the United States found that more than patient-level factors, practice- and provider-level factors accounted for lower use of telehealth video visits by patients facing socioeconomic vulnerabilities such as belonging to non-dominant ethnic groups, being non-English speakers, having lower education levels and living in low-income neighborhoods.²⁴ Based on this finding, authors of the study surmised that healthcare providers who primarily serve socioeconomically vulnerable patients may be less equipped for telehealth video visits or might harbor implicit biases and stereotypes about vulnerable patients being ill-suited for video visits.²⁴

Some providers might also lack requisite skill and training to facilitate telehealth visits. A study conducted with mental health providers primarily serving refugees in the United States found that 53% of providers surveyed felt underprepared and under equipped to use telehealth. Further, less than half reported participating in any telehealth training prior to the pandemic.³ Providers in this study also asserted a need for more education on culturally competent telehealth practices.³ Indeed, telehealth training is not a mandatory component of medical education in many destination countries including the United States, Australia, Germany, and France. Telehealth competencies across healthcare professions are only just emerging.³²⁻³⁷

These trends highlight the importance of building telehealth competencies among clinical providers. In the case of providers who work with refugee and asylee patients, it is important to integrate training in telehealth competencies with building cross-cultural communication skills during telehealth visits.^{3,6} Practices that serve large numbers of refugee and asylee patients also need to maximize workflow efficiency for providers to easily integrate language supports within telehealth visits.²⁴

Table 1: Summary of Barriers and Recommendations

Category	Barriers	Recommendations
<i>Structural</i>	Access to a private web-enabled device and reliable Internet ^{3,7-10}	Telephone-based consultations ^{2,4} Device giveaways or loaners ^{6,7} Assisting with registering and setting up donated devices ⁹ Offering subsidies to purchase internet data plans ⁶ After-hours appointments for patients who share devices and internet access during regular hours ^{4,6} Educating patients about low-cost internet plans ^{2,4,10} Create digital kiosks in public spaces in the community ³⁹
<i>Patient Skills & Ability</i>	Lack of digital literacy ^{3,7,8} Level of education prior to resettlement/asylum ²¹ Limited or emerging English proficiency ^{7,18}	Including digital literacy skills in language classes offered by settlement agencies and other migrant support organization ¹¹ Bilingual community health workers to provide digital literacy training and support ⁸ Virtual patient navigators ^{4,23}
<i>Technological</i>	Unnecessary steps such as patient portal enrollment for scheduling appointments ⁴ Lack of language accommodations within telehealth technology ^{7,9}	If portal enrollment is necessary, providing navigation support ⁴ Patient navigation apps with in-built translation features ²⁷ Creating tip sheets and short videos in multiple languages on self-enrollment ⁹ Add commonly spoken languages to health system ⁹
<i>Communication</i>	Concerns about digital privacy ⁹ Loss of non-verbal communication ³ Limited opportunities for rapport-building ⁶ Difficulties with language interpretation ^{2,6}	Using browser-based telehealth platforms that don't require download ⁹ Having proper caller ID for telehealth visits ² Educating patients about privacy protection measures ⁹ Adopting communication strategies that are more effective for telehealth ^{3,6,7} Offering an introductory in-person meeting before switching to telehealth ^{3,7} Including interpreters via videoconferencing ³⁰ Supplementing verbal communication with infographics and other visual material ⁶

<i>Provider Skills & Readiness</i>	Implicit biases and stereotypes about patients ¹⁸	Offering integrated training in telehealth competencies with cross-cultural communication skills ^{3,6} Maximizing workflow efficiency for providers to easily integrate language supports in telehealth ²⁴
	Lack of skills and training for telehealth visits ³	
	Limited knowledge of culturally competent telehealth practices ³	
	Lack of application of health literacy best practices ³⁸	Require trainings on applying health literacy strategies ³⁸

Implications for practice and policy

Improving the quality and accessibility of telehealth services for refugees and asylees will require concerted effort including, but not limited to:

- Allocation of resources to refugees and asylum seekers receiving centers and CBOs supporting their resettlement to offer digital literacy trainings, loan devices to newcomers with subsidized high bandwidth Internet, provide language proficiency trainings, and orientation to the host country's healthcare system and telehealth practices.
- Creating digital kiosks (smart kiosks) in public spaces to provide easy access to information technology. Evidence indicates that cities around the globe are establishing successful smart kiosks to address a variety of issues.³⁹
- Requiring healthcare providers to be trained in health literacy best practices and have the ability to culturally tailor telehealth communication.
- Ensuring the privacy and confidentiality of all personal information during telehealth visits and educating patients about privacy measures.

Recommendations for Future Research

Future studies should explore aspects of telehealth that can target barriers and facilitate effective delivery of services. One avenue for future research would be to explore optimal forms of telehealth consultation and delivery for this population based on whether patients prefer telephone consultations or videoconferencing. Researchers can explore patient preferences based on social determinants such as prior education, language proficiency, digital access and literacy, and other cultural preferences.^{7,10} There is also a need for longitudinal studies of telehealth outcomes for health conditions that are prevalent among

refugees and asylees.⁷

Finally, additional research is needed to understand telehealth access and experience for refugee and asylee patients from different racial and ethnic backgrounds and different countries of origin. Future research can also shed light on how experiences vary for groups with intersectional experiences such as elderly refugees, refugee/asylee women, refugees and asylees with disabilities and LGBTQI refugees and asylees.^{3,6} These insights can inform future efforts to improve accessibility of telehealth services for refugees and asylees.

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