

# **Assessing Health Inequities: Understanding the Impact of the COVID-19 pandemic on Toronto's Spanish-Speaking Latin American Population**



Canadian Mental  
Health Association  
Toronto

**Wellesley  
Institute**   
advancing urban health

## AUTHORS

Irma Molina, CMHA Toronto  
Sarah Sanford, Wellesley Institute  
Raul Oyuela, CMHA Toronto  
Brenda Roche, Wellesley Institute  
Frank Sirotych, CMHA Toronto

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Canadian Mental  
Health Association  
Toronto

## About CMHA Toronto

CMHA Toronto, a branch of the Canadian Mental Health Association, is the city's leading community mental health agency. We provide accessible, quality care for Toronto residents through programs, research and advocacy that create belonging and hope.

At CMHA Toronto, we take a client-first, recovery-oriented approach to supporting people and their families when they experience mental health challenges or live with mental illness.

By integrating health and social care, we provide services that aid in long-term wellness including housing, employment, community connections and so much more.

Our goal? Help everyone thrive in the community.



## About Wellesley Institute

Wellesley Institute works in research and policy to improve health and health equity in the GTA through action on the social determinants of health. We strive to produce groundbreaking applied research, build skills and capacity and influence policy to decrease health inequities.

Our vision is a healthier and more equitable Toronto for all.

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# EXECUTIVE SUMMARY

This report presents the results of a needs assessment on the impact of COVID-19 on Spanish-speaking Latin Americans residing in the Greater Toronto Area (GTA). The need for this research was first identified by members of the Toronto Latin American COVID-19 Task Force in 2021 while advocating for the needs of communities most affected by the pandemic.

The study used qualitative semi-structured interviews to explore the challenges experienced by twenty-four Latin American participants, including community members and service providers, as they navigated the health, social, and economic impacts of the pandemic.

Despite awareness of inequities in Toronto and other areas, research on the perspectives and experiences of specific communities throughout the pandemic remains limited. Gaining an understanding of the experiences of Spanish-speaking Latin Americans in Toronto can provide insight into the factors that contribute to these inequities and identify the necessary supports and services to effectively address these disparities in the post-pandemic recovery phase.

## MAIN CHALLENGES & RECOMMENDED POLICY DIRECTIONS

The analysis identified four main themes that shed light on the challenges faced by the Spanish-speaking Latin American population in Toronto during and beyond the pandemic. To address these challenges, the report provides recommended policy directions:

### Caregiving Challenges

- Caregivers' health and well-being were negatively affected during the COVID-19 pandemic.
- Caregivers faced increased demands, including greater domestic responsibilities, remote work obligations and providing emotional and mental health support to family members, coupled with limited support and resources.
- Physical distancing and lockdown measures led to heightened levels of stress, burnout, and exhaustion, further exacerbated by feelings of social isolation.
- Balancing daily household tasks while caring for sick family members presented difficulties.

### Recommended policy directions:

- **Increase financial support for caregivers:** Pandemic recovery policies should include provisions for financial support for caregivers, especially for those who are unable to work or who take on other financial risks due to their caregiving responsibilities.
- **Establish comprehensive caregiver support programs:** To address the mental health challenges and overall wellbeing of caregivers, comprehensive caregiver support programs must be established. These programs should include respite care, counseling services, and other forms of support.
- **Address the gender and other inequities in caregiving:** Women and mothers have taken on a disproportionate share of caregiving responsibilities, especially during the pandemic. Programs and policies must be established to address this gender imbalance, along with other intersecting factors (e.g., class, immigrant status).

### Access to Online Health and Mental Health Services

- Spanish-speaking Latin American health service users faced difficulties with web navigation, accessibility, and technical difficulties, which hindered their access to virtual care.
- Participants encountered challenges related to accessing technology (e.g., devices) and the internet, including financial barriers.
- Privacy and security issues, and a lack of access to private spaces for virtual care services were a concern for Latin American users.
- Navigating online platforms and language barriers posed a significant difficulty for some individuals in accessing essential services.

### Recommended policy directions:

- **Increase investment in internet access and digital devices for underserved communities:** Governments should prioritize investing in internet infrastructure to ensure that communities with limited access can participate in virtual care. This should involve initiatives to provide affordable internet and cell phone plans, as well as programs to distribute digital devices to low-income households.
- **Develop digital equity-focused plans and training for healthcare providers:** Health systems and stakeholders should develop clear plans for delivering equitable virtual care. This should involve measures to ensure that services are accessible and culturally appropriate for diverse communities. Sustainable virtual care plans should also consider economic disparities and the potential benefits/challenges of transitioning between in-person and virtual services based on individual contexts.

## Access to Spanish Language Services

- Spanish-speaking Latin Americans faced challenges due to the lack of information and services offered in Spanish during the pandemic.
- There was an absence of Spanish resources regarding restrictions, guidelines and available services during lockdown periods.
- There was a shortage of Spanish translation and interpretation services, as well as bilingual staff (English-Spanish) in health and community services and many Latin Americans experienced long wait times to access Spanish-language healthcare providers.
- There was a shortage of bilingual workers in hospitals and large organizations located in areas with a high population of newcomers and immigrants.

### Recommended policy directions:

- **Increase the number of professional interpreters:** Healthcare settings should be resourced to employ professional interpreters who are trained and qualified to translate language in healthcare contexts.
- **Advocate for consistent, standardized language interpretation services:** Advocacy efforts should continue to push for consistent and standardized language interpretation services in Ontario's healthcare system.

## Uninsured and Those with Precarious Status

- Latin Americans with precarious status faced an increased risk of contracting COVID-19 due to social and economic conditions such as overcrowded housing, (public-facing) essential job roles, and a lack of paid sick days. Many individuals delayed seeking medical attention due to fear or a lack of knowledge about the healthcare system.
- Refugees encountered barriers in accessing healthcare services under the Interim Federal Health Program (IFHP), including being turned away from walk-in clinics and a lack of awareness among clinics regarding coverage eligibility.
- Barriers to accessing mental health services were identified for this group, including a lack of OHIP coverage for refugee claimants once they were granted status.
- Non-status Latin Americans faced significant barriers in seeking medical care or testing at healthcare centers due to fear of deportation or separation from family.

## Recommended policy directions:

- **Increase Awareness and Access to Healthcare Programs:** Increase awareness about healthcare programs and services available to refugees, non-insured residents, and marginalized groups, including temporary or precarious workers. Utilize community outreach programs, public education campaigns, and partnerships with local non-medical immigrant settlement organizations to disseminate information effectively.
- **Reinstate the Physician and Hospital Services for Uninsured Persons Program:** Reinstate and standardize the Physician and Hospital Services for Uninsured Persons program across hospitals in Ontario. Establish clear billing processes to streamline the provision of services to uninsured individuals.
- **Increase Funding for Community Health Centers and Uninsured Health Clinics:** Increase funding for community health centers and uninsured health clinics to improve access to primary healthcare services for uninsured individuals. Ensure these centers and clinics are adequately equipped to meet the needs of the target populations and support collaboration with immigrant settlement organizations serving similar populations.
- **Educate Healthcare Professionals:** Provide comprehensive training to healthcare professionals regarding the available healthcare options for uninsured individuals. Ensure that healthcare professionals are equipped with the knowledge and skills necessary to provide appropriate care to this population.



# INTRODUCTION

The COVID-19 pandemic has had a profound impact on communities throughout the Greater Toronto Area (GTA), exacerbating existing health, social, and economic disparities. Among those most affected are historically marginalized populations, including racialized,<sup>1</sup> immigrant, refugee, and newcomer communities.<sup>2</sup> Latin Americans in Toronto, in particular, have been disproportionately impacted.

Latin Americans, like many other racialized and immigrant populations, are more likely to experience inadequate living and working conditions, which have made them more vulnerable to COVID-19.<sup>3,4</sup> This includes factors such as lower incomes and precarious employment,<sup>5,6</sup> limited access to health and social services, pressure and stress caused by structural racism and discrimination,<sup>7,8</sup> difficulties in limiting COVID-19 exposure due to essential work activities, and challenges in physical distancing.<sup>9</sup> Despite these significant challenges there is a lack of research on the specific impact of the pandemic on the Latin American population in Toronto.

This report presents the results of a needs assessment conducted by the Canadian Mental Health Association (CMHA) – Toronto Branch and Wellesley Institute. The need for research on the impact of COVID-19 on the Latin American population was first identified by members of the Toronto Latin American COVID-19 Task Force<sup>10</sup> in 2021 while advocating for the needs of groups and communities most affected by the pandemic, including better access to vaccines and culturally appropriate public health approaches.

The needs assessment explores the experiences of Latin Americans who contracted COVID-19, had family members and friends who were sick from the virus, and/or provided services to Latin Americans in the GTA. The report provides insights into the physical and mental health needs of Latin Americans during the pandemic, including the challenges they faced and the supports they accessed. Additionally, the report highlights the barriers that prevented access to necessary supports and identifies some directions forward for promoting the provision of equitable and appropriate services for this population.

# BACKGROUND

## THE COVID PANDEMIC AND INEQUITIES IN ONTARIO AND THE GTA

The COVID-19 pandemic has had a significant impact on the mental health and well-being of the population in Ontario.<sup>11,12</sup> In addition to the stress of social isolation due to two years of public health physical distancing measures,<sup>13</sup> people have struggled with changed circumstances, such as navigating remote or in-person essential work,<sup>14</sup> and increased caregiving responsibilities for dependent children, sick family members and those with disabilities and other needs.<sup>15</sup>

Despite shared difficulties, it quickly became clear that the health, social and economic impacts varied throughout the population. Some major inequities have played out in terms of the burden of risk and outcomes from the COVID-19 infection. These inequities are the result of the unequal distribution of the social determinants of health, information, and resources, and the lowered capacity of some groups to access protective strategies and treatments.<sup>16</sup>

Research in Canada has found that racialized and low-income populations experience higher rates of COVID-19 infection<sup>17</sup> and mortality.<sup>18</sup> Early in the pandemic, neighborhoods with higher proportions of low income, immigrant and racialized populations, as well as more crowded and substandard housing represented disproportionately high rates of COVID-19 in Ontario and Toronto.<sup>19,20,21,22</sup> Racialized individuals in Toronto represented approximately two-thirds of reported COVID-19 cases and hospitalizations as of December 2021.<sup>23</sup> Racialized workers are overrepresented in certain essential occupations which have shouldered an inequitable burden of transmission and deaths during the pandemic.<sup>24,25</sup>

The pandemic has further highlighted the need to address healthcare inequities. Pre-existing barriers to healthcare became even more apparent during the pandemic with stark inequities in COVID-19 testing rates and vaccine access for marginalized populations in Ontario.<sup>26,27</sup> Initially, vaccine rates were lower in low-income neighborhoods, with more residents who were racialized, immigrants, essential workers, and living in crowded housing.<sup>28</sup> Research from the pandemic has shown that Black and trans and non-binary populations experienced considerable barriers to accessing culturally safe care in Canada.<sup>29,30</sup> Difficulties accessing other forms of healthcare, including mental health, have also been documented for some groups (e.g., racialized immigrants).<sup>31</sup>

### Experiences of Latin Americans During the Pandemic

Despite the fact that racialized and low-income groups have borne the burden of pandemic inequities in Toronto, Ontario and Canada, there continue to be gaps in knowledge about the experiences of specific sub-populations during this time. One example is that of the Latin American population which was particularly affected with higher rates of COVID-19

infections, hospitalizations and deaths.<sup>i</sup>

According to the 2021 census, 156,455 Latin Americans reside in Toronto,<sup>32</sup> although some sources suggest that the number is actually higher. In Toronto, 3% of the population identify as Latin American, yet 8% of all COVID-19 cases between May 2020 and March 2021 were from this group.<sup>33</sup> During this time, Latin American immigrants had the second highest mortality rate among immigrant communities in Canada.<sup>34</sup> Latin Americans, among other racialized groups, have also had a lower rate of vaccination than non-racialized residents in Ontario.<sup>35</sup>

In addition to the risk posed by the virus and barriers to healthcare, the pandemic represented a time of financial hardship for many, as some sectors laid off employees or reduced work hours. In 2020 Latin Americans experienced significantly higher unemployment rates compared to the non-racialized population in Canada (13.9% versus 9.4%).<sup>36</sup> Other research shows that this group faces greater barriers to economic security compared with the remainder of the population in Canada.<sup>37</sup> Although government emergency measures, such as the Canadian Emergency Recovery Benefit (CERB), were helpful for some workers, others faced challenges accessing these supports.<sup>38,39</sup>

Research on the experiences of members of racialized populations in Toronto found that pandemic stressors, including those related to decreased economic security (e.g., low income and unstable housing), had a substantial impact on people's mental health and well-being.<sup>40,41,42</sup> Latin Americans in Canada reported lower self-rated mental health than the non-racialized population during the pandemic, with a significant decrease in high self-rated mental health from Fall 2020 to late 2021/early 2022 (68% to 43%). This represented a greater decline compared to other racialized groups in Canada.<sup>43</sup>

There is also limited knowledge of challenges faced by specific groups within the Latin American population. Qualitative research on deaths of Ontario migrant agricultural workers from Mexico, the Caribbean, and Central America from 2020-21 revealed that substandard conditions of healthcare monitoring, quarantine and isolation, in addition to challenges accessing medical care were some of the main factors contributing to the heightened vulnerability and potentially preventable deaths of these individuals.<sup>44</sup>

Existing research indicates that Latin Americans have been disproportionately impacted by the pandemic compared to the general population. Yet questions remain about why this group faces greater risk and worse health and other outcomes compared with the rest of the population. Research remains limited on the perspectives and experiences of

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i The Latin American population in Canada is very diverse with individuals coming from different countries of origin and sociodemographic backgrounds. Latin American is generally used to describe groups and individuals who trace their historical, familial, ethnic and cultural roots to the geographic region colonized by the Spanish, Portuguese and French states, and which encompasses Mexico, Central America, South America and parts of the Caribbean. In their definitions, Statistics Canada and other government institutions use Latin American as a category for "visible minority" identity and tend to include Central and South America, but exclude some Caribbean nations, where people may also identify as Latin American. For this study, the definition is also limited to Spanish-speaking individuals, due to the language skills of the research team.

specific communities throughout the pandemic, despite knowledge of inequities in Toronto and elsewhere. Understanding of the experiences of Spanish-speaking Latin Americans in Toronto can shed light on factors contributing to inequities, as well as what supports and services are needed to better respond to these disparities after the COVID-19 pandemic.

## METHODS

This research explores the experiences of Spanish-speaking Latin Americans who have contracted COVID, or who cared for someone with COVID-19 in Toronto during the pandemic. A community advisory group was established at the onset of the project. The advisory group included Latin Americans in the GTA who have a history of involvement in direct community service provision and/or advocacy related to the Latin American population. The research benefited from the input of the advisory group during key stages of the study, including design and recruitment, analysis and interpretation of findings and planning for knowledge mobilization.

To explore the challenges faced by members of this community in coping with relevant health, social and economic impacts of COVID-19, including the availability of supports and experiences with health and other services, qualitative semi-structured interviews were conducted with both community members and health and social service providers serving the community.

Community member participants were included in the study if they self-identified as being Latin American, spoke Spanish, resided in the GTA, were 18 years of age or older, had contracted COVID-19 since early 2020, or had cared for someone who contracted COVID-19. Service providers were included in the study if they provided health or social services to the Latin American community during the pandemic.

Members of the research team and of the community advisory group recruited study participants through their networks using recruitment materials such as flyers. In addition, for service provider interviews, the research team identified potential participants based on their expertise and invited them to participate in the study via publicly available email accounts linked to the organizations where they worked.

Individuals interested in participating in the study contacted one of the members of the research team via email or phone and were screened for their eligibility. A purposive sampling strategy was used to attempt to increase the diverse representation of participants, based on self-identified gender, sexual orientation, place of birth or age.

Data collection was coordinated and conducted by CMHA's Peer Program Evaluation Project (PPEP) which hires and trains people with lived experiences of mental health and addiction challenges (peers) to undertake program evaluation and community-based research.

Interviews took place from September to December 2022. Almost all of the interviews were in Spanish with two service provider interviews conducted in English. Interviews took place via telephone or video call and were audio-recorded and transcribed verbatim.

Participant interviews explored physical and mental health needs, the social and economic challenges facing Latin Americans, experiences accessing the health care system and community services, and barriers and gaps in services and supports.

Interview transcripts were analyzed by the project team using a thematic analysis approach.<sup>45</sup> Analysis involved an inductive technique where emerging codes were generated using a systematic approach and derived directly from the data. Data was first organized according to a list of thematic codes, discussed within the project team and codes were then revised and applied across all transcripts. As analysis progressed codes were gathered into broader themes which were then organized and refined with ongoing engagement with the data.

Ethics approval for the research was granted by the Community Research Ethics Office, Centre for Community Based Research in August 2022 (REB # 2022-258).

## DESCRIPTION OF SAMPLE

The sample included a total of twenty-four Latin American participants. Fifteen shared their experiences of either having COVID-19 or taking care of someone who had COVID-19 and ten shared their experiences of providing services to the Latin American population. One participant shared her experiences as both a caregiver and service provider.

Table 1 provides a summary of the key sociodemographic characteristics of participants who either contracted COVID-19 or a family member or friend who cared for someone who did. Most in this group were in their 40s and 50s, with eight identifying as female and seven as male. None of the participants identified outside the gender binary. Most identified as heterosexual, with one identifying as gay and one as queer.

Most of the participants in this group were born outside of Canada and came from countries such as Chile, Colombia, Cuba, El Salvador, Honduras, and Mexico. At the time of the interviews, five participants had been in Canada for 1-5 years (newcomers), and eight had been in the country for ten years or more. The majority of the participants reported learning Spanish at home during childhood and still understood the language. One participant reported an indigenous language as their mother tongue.

Regarding health insurance coverage, most participants were covered by OHIP, while two were covered by the Interim Federal Health Program (IFHP),<sup>ii</sup> one by University Health Insurance Plan (UHIP), and one was uninsured. In terms of income, six participants reported that their income did not meet their needs.

For service providers, the areas of service included social work, youth care work, personal support work, nursing, healthcare administration, family services, counseling, psychotherapy, and mental health clinical work.

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ii The IFHP is a temporary health insurance program for refugees, protected persons, and refugee claimants in Canada. UHIP is the compulsory plan for those working and studying at universities in Ontario who do not have coverage.

**Table 1: Participants who had COVID-19 or took care of someone with COVID-19**

Characteristics		Interviews: Number (%) of Total: 15
<b>Age</b>	20s-30s	5 (33)
	40s-50s	8 (53)
	70s-80s	2 (13)
<b>Gender</b>	Female	8 (53)
	Male	7 (47)
<b>Sexual Orientation</b>	Gay	1 (7)
	Queer	1 (7)
	Heterosexual	13 (86)
<b>Place of Birth</b>	Canada	2 (13)
	Chile	1 (7)
	Colombia	2 (13)
	Cuba	2 (13)
	El Salvador	1 (7)
	Honduras	1 (7)
	Mexico	6 (40)
<b>Years in Canada</b>	Born in Canada	2 (13)
	1–5	5 (33)
	10 +	8 (53)
<b>Language Learned at Home and Still Understand</b>	Spanish	14 (93)
	Indigenous language	1 (7)
<b>Health Insurance</b>	OHIP	11 (73)
	Interim Federal Health Program (IFHP)	2 (13)
	University Health Insurance Plan (UHIP)	1 (1)
	Non-insured	1 (1)
<b>Income Meets Needs</b>	Yes	9 (60)
	No	6 (40)

# FINDINGS

Four main themes were identified through the analysis. These themes included 1) the particular challenges faced by caregivers, 2) limited access to online health and mental health services, 3) the lack of services available in Spanish, and 4) the barriers experienced by people with precarious immigration status.<sup>iii</sup>

Participants who either contracted COVID-19 or cared for someone affected by it emphasized the first and last themes, while the second, third, and fourth themes were predominantly discussed by service providers.

In order to adequately represent the distinct perspectives of both participant groups, the findings from each group are presented in two separate sections. The first section focuses on the experiences shared by participants who contracted COVID-19 or cared for someone affected by it. This section highlights the experiences of caregivers and participants with precarious immigration status.

In the second section, the focus shifts to analysis of service provider insights. This section highlights the challenges related to accessing virtual care, the limited availability of services in Spanish, and the difficulties faced by Latin Americans with precarious immigration status when seeking healthcare services.

Overall, the experiences and perspectives of participants provide valuable insights into the systemic issues and barriers that need to be addressed to improve healthcare access and equity for underserved communities.

## 1. EXPERIENCES OF PARTICIPANTS WHO HAD COVID-19 OR CARED FOR SOMEONE WITH COVID-19

Study participants shared some of the ways in which the pandemic affected their lives. Most felt disconnected socially from the community and this led to many feeling separated from systems of support. Many participants reported lacking access to important health information and described a lack of information available in Spanish regarding restrictions and available health services.

Lockdown measures and related public health measures had additional consequences for individuals. Some participants reported a reduction in work hours or losing their jobs. Others described having to move in with unsupportive relatives or sharing accommodations with strangers. Furthermore, many participants reported an increase in home and family pressure and responsibilities, particularly for caregivers.

Participants also discussed the challenges they faced during the time they had COVID-19

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iii Precarious status refers to individuals who have an immigration status that is neither permanent nor guaranteed. In Canada, precarious status encompasses temporary workers, students, and refugee applicants who are officially documented, as well as those who have unauthorized forms of status, like visa and permit over-stayers, failed refugee claimants, and undocumented entrants. [Reference: L. Goldring, C. Berinstein, and J. Bernhard's (2009). "Institutionalizing Precarious Immigration Status in Canada" in *Citizenship Studies* 13(3):239-265].



or were taking care of family members or friends who were sick with COVID-19. Those who were sick reported experiencing severe symptoms, including persistent diarrhea, abdominal pain, and vomiting, which often led to feelings of hopelessness, especially among those who were bedridden. Two participants, for example, recounted the difficulties their family members faced after contracting the virus. They suffered from high fever, headaches, body pain, and shortness of breath. In addition, one participant's senior relative, who was diabetic, experienced severe diarrhea for over a month, making the recovery process even more challenging:

*"We had high fever and had three or four days without eating almost anything. With headaches, high fever, body pain, and bone pain... We felt very, very bad, because at one point I felt that I could not even breathe, I mean, it was hard to breathe."*

*"My dad got very sick with the virus because it attacked his stomach. He had horrible diarrhea that could not be contained for more than a month. And he is diabetic and so we were very scared because he became very unbalanced. So he was the one who took the longest to recover. It took him about a month."*

Most participants emphasized the importance of informal support from family members and close friends who provided assistance with everyday activities, such as providing cooked food, groceries, medication, and home remedies. They also offered emotional support during these challenging times.

Participants also discussed the pandemic's impact on mental health and well-being. They described experiencing stress, anxiety, fear, sadness, and loneliness, particularly when infected with COVID-19 or caring for others who were sick. They also experienced worry for sick family and friends and feelings of loss and grief for those who passed away due to COVID-19. Three participants, in particular, discussed their intense anxiety and fear due to concerns about contracting the virus, the toll that prolonged isolation and stress took on their mental and physical health, and the severity of depression that led to suicidal thoughts:

*"When I had to go shopping or to the supermarket, the [anxiety] attack started. I could not even enter the store because I knew I could not breathe. And it was very difficult, because I would say 'I'm going to faint, I'm going to faint.' I mean, you can't control your feelings. Well, the truth is, I felt like I was going to die; it feels horrible, I mean, the most worrying thing for me is because a relative of mine died of COVID... just like many people are dying, I did not want to be one more of those people. I think that was the hardest thing."*

*"More than anything, I had depression and anxiety. And I started with that because of so much confinement. Then my hair started to fall out and [I had] anxiety, stress and body pain, something so horrible. And it was really very difficult."*

*"[I had] a lot of depression like I had never felt before in my life. Quite severe depression, I mean, suicidal thoughts and from there you can imagine."*

Study participants reported following public health recommendations to stay home during the time they were sick with COVID-19. Only a small minority who experienced



severe symptoms sought medical attention, visiting family doctors or hospital emergency departments. The majority of participants (13 out of 15) had already been vaccinated by the time they contracted COVID-19. Most reported accessing the vaccine through community-based clinics that offered Spanish translation and did not require OHIP. In terms of formal support, only one participant reported benefitting from the Canadian Emergency Response Benefit (CERB), while two accessed mental health support (therapy) through the IFHP.

While most participants shared similar experiences, two groups confronted specific challenges. First, caregivers were greatly affected by the pandemic. They struggled with increased responsibilities and limited support while caring for sick family members. The majority of caregivers in the study identified as female and mothers. Second, participants with precarious status also faced unique challenges, including delayed immigration processes, separation from family and barriers to accessing healthcare. The sections below provide insight into the experiences of these two groups during the pandemic, highlighting the various challenges they faced and how it impacted their lives.

## Caregivers

The pandemic posed significant challenges for caregivers, including increased responsibilities and demands, limited support and resources, and heightened stress and burnout. In the context of public health lockdowns and restrictions in movement, caregivers reported feeling overwhelmed and exhausted from juggling multiple responsibilities, such as work, and caring for sick family members.

The pandemic added layers of pressures to existing caregiving roles and responsibilities. In addition to having greater responsibility some people described experiences of isolation where they were cut off from their support networks. One participant who was caring for two children experienced isolation following separation from their partner:

*“I got separated, like the first week of the pandemic. And so I had to move out of the home with my two children...COVID made it more difficult because there was an element of isolation from my peers at work, from my colleagues and from being able to visit family or family coming to visit the house.”*

The increase in caregiving responsibilities due to the closure of schools and other institutions was made more difficult by sudden detachment of people from their family, social and professional connections which previously might have provided important supports.

The physical separation also limited some people's ability to care for others as they typically had before the pandemic. One participant described being unable to care for her mother and brother, in addition to her children, while she was sick:

*“And for me it was very hard because during the time that I was taking care of my kids and also the time that I was sick, I was not able to go and see my mom. And I [usually] go see her everyday in complex care. And so taking care of other family members (my children who were affected by COVID and then myself) greatly impacted my ability to care for someone else ... I also have a brother who is*

*immunocompromised.”*

Caregivers described having to contend with their own health concerns while also caring for others. Most contracted COVID-19 shortly before, during, or after taking care of ill family members, which added physical and emotional pressure, amplifying existing difficulties within the home. One mother described the severe physical pain and distress she experienced as she tried to prepare meals for her sick children and alleviate their symptoms:

*“[S]eeing my two children sick and my husband and I too... even so, I would get up and if there was no one outside in the kitchen, I would go in with my mask and, even though I felt awful, I would prepare something for them to eat.... I had to do it, I mean, at the end of the day I did it, and sometimes I didn’t even sleep. And so with their body aches and the fever, I put wet wipes on their foreheads, on their bellies, on their legs.”*

This mother struggled to look after the physical needs of her sick family while also suffering from COVID-19. She also expressed that she would have been less distressed if she had received assistance; in her words “at least someone that could bring [them] a plate of food” or financial support “to be able to get food delivered” to their door.

Caregivers reported intensified difficulty maintaining daily household tasks and trying to clean shared spaces to prevent the spread of infection. Some caregivers shared their experiences of having to take on additional tasks such as taking out more garbage, washing dishes with hot water, and disinfecting bathrooms frequently:

*“And then, for me it was overwhelming because as family members were getting sick, I was the one taking care of everyone else who was sick. I was taking out the bags full of tissues they used to blow their noses, all the Kleenex... I was [taking the garbage out]... I had to wash all the dishes and everything they used, I washed them with super hot water that burnt my hands.”*

*“My tasks and working hours multiplied by I don’t know how many times... the bathroom, every time one of them used the bathroom, I washed the entire bathroom completely with everything, with disinfectant... and later one by one got sick, first one, then two and three, until all four [were sick]”*

Other challenges included balancing domestic and remote work responsibilities as well as providing emotional support to family members. Some had to deal with the mental health problems of their family members, particularly children who had been affected by the lockdowns and social distancing measures:

*“It was difficult to deal with all the mental health problems of the family, of the children who were locked up. The situation became unbearable because all social life was affected in the house...internally we felt like a lot of fear when going out, when touching a door, touching clothes, touching everything, it was like that fear of ‘I can’t touch this, I can’t touch him, if I touch him, I wash my hands.’ We had cuts in our hands from so much hand sanitizer. The children, imagine the children locked up all the time.”*

This quote highlights the toll that the pandemic had on some families, particularly in terms of negatively impacting mental health, and adding to fears and social isolation. Caregivers faced a greater burden of responsibility under pandemic conditions and generally noted the lack of support that they received looking after themselves and others during this time.

## **Participants with Precarious Immigration Status**

The issue of precarious immigration status was raised in the interviews as a unique challenge for some Latin Americans living in Toronto. Two participants who were refugee claimants described additional challenges that they experienced throughout the pandemic. These included delays in immigration hearing processes, travel restrictions, and barriers to accessing healthcare services, including discrimination.

During the first few years of the pandemic, there were major delays in government immigration, refugee and citizenship processing times. This waiting meant that some people living without permanent immigration status were left in a state of uncertainty. One participant reported that the delay in his refugee claim hearing for over two years left him feeling frustrated and insecure:

*“[A]nother aspect that also frustrated us was that our immigration hearing was suspended, our case was postponed for 2 more years. Because we had our hearing this year [2022] in February, since we came in 2018. So that has made us even more frustrated. Because we can’t do anything, we can’t leave the country. There’s no way to speed up the process, no one answers when I call. We were like in limbo.”*

Having to wait an additional two years for a hearing meant being unable to make plans and left this participant feeling helpless. Another issue impacting these participants were the travel restrictions they experienced. Both shared the pain of losing someone abroad and experiencing family separation during the pandemic, because of their immigration status:

*“I lost my father in early 2021, he died of COVID in my country... that affected me a lot, because obviously my immigration status is refugee claimant, so I cannot leave the country...I felt overwhelmed, frustrated, disappointed, because I thought about leaving everything and going back to my country.... But I couldn’t because the airports were not working. So, [I was] basically with my hands tied in all aspects.”*

*“[The pandemic and the closing of the borders] has been the most difficult... I could not bring my children [into the country]. It was complicated, being so far away from them and they not being able to enter [the country]. They came almost three years later. The truth is that being separated [from my children] for so long and not being able to do anything about it, was very difficult for me.”*

The inability to travel to their country of origin to grieve the loss of family members and extended separation from children due to restrictions around immigration status and pandemic travel was extremely impactful for the first participant. These experiences were very difficult for participants to cope with and undermined their mental health and well-being.

Refugee claimants also described difficulties in accessing health services. People with

refugee status are entitled to access to healthcare through the Interim Federal Health Program (IFHP). Access to healthcare services under this program is connected to specific administrative requirements that can function as barriers to care. As two participants pointed out, some health providers were reluctant to provide services under this program:

*“It’s complicated, because even when we go for an exam, an x-ray, or any procedure, if we show our brown [IFHP] form...[health providers] don’t like it because they tell us ‘you bring one of these forms, it’s more of a process for us... this takes longer.’”*

*“Sometimes we feel that they serve us unwillingly because they have told us, literally, ‘this process for us is more complicated’ or ‘sometimes the government does not pay, so that is why we don’t accept this brown form’; it’s called ‘brown form’... it is a big sheet, with our photo and date of birth.”*

While refugee claimants faced challenges dealing with the administrative requirements for accessing healthcare services through the IFHP, those without OHIP coverage encountered even greater barriers to accessing care. In two instances, for example, participants without OHIP shared that they did not seek medical attention at the hospital, even when experiencing severe symptoms. One participant who was unaware of the Ontario Government’s temporary measure to extend health care to uninsured residents during the pandemic shared her distress at experiencing severe respiratory symptoms while having limited access to healthcare:

*“I told the person who was taking care of me, I said ‘take me to the doctor’ and he said ‘I can’t take you to the doctor because you don’t have insurance; how are they going to treat you?’ And I felt short of breath and it was choking me. I was getting weaker, in fact they had to carry me to the bathroom because I couldn’t even walk... My only salvation was my roommate; he was the only one who supported me at the time. When I went to the health center... they told me ‘you can wait at home.’ And since I don’t have insurance, I had no choice but to stay at home...I would have liked to attend a medical institution and receive medicine and the attention that I really needed at the time.”*

This quote also suggests a lack of understanding and awareness on the part of the health center that the participant eventually tried to access which ultimately resulted in a lack of access to medical care. A similar situation was described by a caregiver who was caring for two non-insured relatives:

*“It was a difficult experience... the fear of what would happen if I took them to the hospital. [I wondered] ‘should I call an ambulance? How much will they charge me for not having insurance?’ It was a headache and stress because they were very sick, it was stressful and painful... Now I regret not taking them to the hospital, because we didn’t know the process, because we were completely lost [without knowledge] and we didn’t know what they would tell us in the hospital.”*

These quotes suggest substantial barriers to appropriate healthcare services for people with IFHP insurance or who were lacking insurance all together. Participants with precarious

status were especially distraught by the lack of clear or safe pathways to accessing the medical care that they needed during the pandemic. While the two relatives referenced in the last quote ended up recovering after about a month, their roommate who they contracted COVID-19 from (and who was insured) was taken to the hospital and died within a few days.

## 2. SERVICE PROVIDER EXPERIENCES

Service providers highlighted several challenges faced by the Latin American population in Toronto. These included difficulties around access to virtual care, a shortage of Spanish translation and interpretation services and a lack of bilingual (English-Spanish) staff. They also noted that Latin Americans with precarious immigration status were particularly affected by the pandemic due to living conditions and limited access to health and social services. The following sections discuss these challenges in more detail.

### Difficulties Accessing Online Services

The transition to providing online services proved to be a major challenge for Latin American users, especially early in the pandemic. Service providers offering direct services, such as mental health counseling or psychotherapy, shared specific challenges experienced by users. These included difficulties with web navigation and accessibility, access to technology and the internet, as well as privacy and security issues.

Latin Americans who had to engage with virtual care for the first time during the pandemic faced significant obstacles, particularly those not familiar with navigating online platforms. Individuals with language barriers encountered even more difficulties in accessing essential services, as one service provider shared:

*“One thing about service accessibility is that during the pandemic, and especially now, everything is on [organization’s] websites...it’s really hard to navigate those services because when you call a number, you don’t find answers. Then you have to call another place and then you’re just going around and...around and it’s not a straightforward referral process. So for some of them it was really difficult to get access to mental health services... And because of the language barrier, that is even worse.”*

Service providers described new challenges around processes like referral to mental health services created by the rapid emerging reliance on virtual systems. Limited access to technology was also a significant barrier to care. In addition to financial barriers associated with purchasing devices and internet services, some service users were unable to use technology, and this prevented access to virtual care:

*“But there was a transition period where services switched from face-to-face to virtual due to COVID; virtual, being over the phone or via video. One challenge that we faced at that time, when we were making the transition, was that many of the patients did not have access to technology to connect virtually, whether it was a phone with a camera or a computer or a tablet, this was a barrier that existed... So there were access barriers due to economic factors or a lack of knowledge on how*



*to use the devices.”*

*“So for some, for the youngest ones, it was easier. But for my seniors, I have women, senior women that didn’t know how to use the technology or they didn’t have devices or use tablets or computers. So I still have some clients that I do over the phone.”*

In addition to financial barriers to purchasing equipment, people faced challenges related to a lack of knowledge about how to use the technology even if they were available. Much of the focus related to digital access early in the pandemic was on making devices available, whereas there was comparatively little dialogue around other barriers to uptake, including those related to knowledge and language. Another participant pointed out that people did not always have access to living conditions or other spaces that would enable them to complete counselling sessions in private:

*“We explored different platforms and well, there were all the technical problems you could imagine, where clients couldn’t connect, the audio wasn’t working and all that... And it was a strong adaptation process, where well, we had to adapt... And in a way, adapt to the fact that the consultations would take place with the required privacy... and all those things that you have to clarify from the beginning and adapt all the initial documentation, all the therapy agreements... [for example] that [they] don’t connect in restaurants, in gyms, in places where they can’t guarantee privacy.”*

Given these limitations, service providers emphasized the need to make virtual care more accessible and inclusive for the Latin American population.

## **Access to Information and Services in Spanish**

Service providers agreed that one of the main challenges faced by Latin Americans during and after the pandemic was the lack of information and services offered in Spanish. They noted that during the lockdown period, there was a significant absence of Spanish information regarding restrictions, guidelines, measures, and available services. Two service providers shared their experience as follows:

*“[I]n the initial stage it was difficult for the Latin American population to know about and understand the virus, the tests, the quarantine, why they had to stay at home so many days and I believe that the greatest impact in that sense was [a result of] not speaking English.”*

*“[B]ased on my work experience, I just feel that there was a lag in translating, you know, all of this information for the Latin American community; a lot of it at the beginning was very heavily English based. And, you know, if English isn’t your first language and you’re listening to the media, reading newspapers, you know, you’re not getting all of the information or you’re getting it quite delayed or you’re relying on family members to tell you what is happening.”*

Service providers also linked the lack of Spanish language information to concerns about the lack of transparency and reliable information from official sources. For one service provider, conflicting information provided by government and other health sources along

with the shortage of information fueled fear, a disregard of COVID-19 protocols, and general mistrust in government information:

*“I feel that there was a lot of conflicting information and no one really knew what you were supposed to do. Like Toronto Public Health would issue a statement, then our hospital organization would issue another statement that wasn’t in sort of agreement with that. And so I just felt like nobody really knew what they were doing...”*

*“lot of the people that I know who are Spanish speaking; speak English as their second language, it was either they were living in fear because I don’t think they had the right information or they weren’t abiding by any of the policies [because they did not trust government information]... There was not really an in between.”*

Service providers also identified a shortage of Spanish translation and interpretation services, as well as bilingual staff (English-Spanish), in the provision of health and community services. Most noted a shortage of bilingual workers in their organizations, relative to the Latin American population they served. As a result, Latin American service users often experienced long wait times or were unable to receive services until a Spanish-speaking provider was available. The shortage of bilingual workers was also noted by service providers working in hospitals and large organizations located in areas with a high population of newcomers and immigrants. One participant shared how the absence of services in Spanish affected not only newcomers but also Latin Americans who have been living in the GTA for more than five years:

*“I think that older adults find it harder, for example, because of the language barrier, and they often rely on their children to take them to different places, translate for them, and bring them back. They often tell me, ‘I don’t want to speak because I don’t want to be a problem for my son.’ So many things are left unspoken and they struggle to meet their needs more independently here, this is due to dependence and fear of going outside, getting lost, or not being assisted with patience.”*

Within this context, service providers emphasized the need for more translation and interpretation services and hiring of more Spanish-speaking service providers in hospitals and walk-in clinics:

*“I believe that interpretation services should be present in walk-in clinics by law... that interpreting services be in each clinic, in all of them... and that the doctor can understand [the patients]. That the receptionist can understand because many come and can’t even communicate with the receptionist...clinics are the first point of access they have.”*

*“Yeah, I think just having access to interpretation, regardless of where they access services, so you know the expectation is not that all people who identify as Latin American go to a Latin American organization, but they should be able to access services and healthcare across Toronto, across Ontario... and it needs to be provided in a culturally relevant manner, but also in a language that they understand and comprehend and can communicate in, so I think. Yeah, just having access to that I think would be helpful because then I think people would be willing and able to go anywhere that’s close to home, yeah.”*

Most service providers stressed the importance of fostering collaboration between Spanish-speaking healthcare providers and promoting coordinated services among healthcare and social service providers. Additionally, they emphasize the need for community-based strategies to increase awareness of Spanish-language services, such as advertising in local churches, supermarkets, ethnic businesses, and other relevant venues.

Some service providers highlighted the success of community-based vaccination clinics, which made vaccination more convenient and accessible at the height of the pandemic, addressing not only linguistic but also geographic and economic barriers. For these service providers, these clinics can serve as models for providing healthcare services in the GTA, especially in under-served neighbourhoods.

## **Latin Americans with Precarious Status**

There was some alignment between the experiences of participants with precarious status and the perspectives of service providers. Service providers also discussed access to healthcare services and emphasized the importance of inequitable access to the social determinants of health for this group.

Most service providers agreed that among Latin American groups, newcomers and people with precarious status were the most affected by the pandemic. Service providers pointed out that COVID-19 case rates were higher in areas with high numbers of Latin American immigrants with precarious immigration status as residents. Many of these residents faced stressful social and economic conditions such as living in crowded homes where they were unable to properly isolate, engaging in essential, in-person, work activities, and barriers to accessing health or social services.

One service provider who worked in a neighbourhood that had high COVID-19 rates at the beginning of the pandemic, provided insight into the issue of overcrowded housing:

*“I am talking about several generations; grandparents, parents and children [who live together]...they live here and work and...we find many Mexicans living in these areas who come here with temporary visas and work, and many live together; for example, I learned of a case where fifteen people lived in a one-bedroom apartment.”*

The participant pointed out that economic barriers (i.e., high cost of rent) meant that workers with precarious immigration status who often earn low wages were more likely to live in conditions which put them at greater risk for acquiring COVID-19 and transmitting it to others. Another service provider shared a similar situation:

*“I know of cases of entire buildings where we knew there were at least seven or eight apartment units where clients were living together in two bedrooms with 14 other people and in this case ...of course they all worked, they all went out on the street daily, during the pandemic, when everything was shut down.”*

As these quotes demonstrate, Latin Americans with precarious immigration status experienced heightened stress during the pandemic related to social and economic



conditions. This group faced greater risk of contracting COVID-19 because they continued to work in essential job roles (e.g., bakeries, construction, cleaning) and relied on public transportation to get around.

Moreover, many were forced to work while sick with COVID-19 because they lacked paid sick days in their positions. One provider who worked with refugee claimants felt that the loss of financial resources was “more stressful than actually contracting the virus” for some individuals. She shared that most of the people she worked with continued to work while sick with COVID-19:

*“It’s a vulnerable population, so they have a lot of financial stress. So they were working at restaurants or greenhouses. Yeah, they have to. They have to work. And because of the kind of jobs there is not like full sick days. It’s not that they can just take some days off. For this population, they need to work or otherwise they won’t be paid. So that’s, that’s the reason why I found that many kept working. Even though they were sick.”*

Service providers stressed the role of poor social and economic living conditions in creating heightened vulnerability for Latin Americans with precarious status throughout the pandemic and beyond.

## **Barriers to health care access – Latin American refugee claimants**

Service providers described other challenges facing Latin Americans with precarious status, particularly for accessing health services throughout the pandemic. Regarding refugee claimants insured under the IFHP, they echoed the lived experiences of participants described above and raised concerns that refugees from Latin American countries were being turned away from walk-in clinics despite having the right to healthcare under immigration and health policies.

Service provider participants described the reluctance of many walk-in clinics to process the patient’s claim reimbursement from the federal government, because of the additional administrative work:

*“[I]t is very common for a refugee [claimant] from... a Latin American country to come and tell us ‘well, I’m tired of going to a walk-in clinic and they tell me they can’t treat me’, when in fact it is very clear in the immigration and health policies [that they have the right to healthcare]. The only difference is that the refugee [claimant] has protection at the federal level, but the walk-in clinics don’t want to go through the trouble of seeing the patient and then sending the receipt to charge that appointment to the federal government. Basically, to avoid an administrative step, many times they are denied health care. A person can visit 3 or 4 places sometimes until they get to centers like ours.”*

In addition to administrative issues, lack of awareness among walk-in clinics regarding coverage eligibility was discussed as a barrier for refugee claimants. One service provider shared that some clinics refuse to accept non-English speaking patients or even charged them for consultations:

*“And just to have access to mental health, so that I can see them, they need to bring a referral from the doctor... So it is very complicated because there are many walk-in clinics that do not accept them because they don’t speak English, they don’t have translation services, interpretation services. We had clients say that they [walk-in clinics] even want to charge them for the consultation, which I do not understand; I believe that there is also a lack of knowledge within the walk-in clinics that these clients can be covered.”*

These barriers had the potential to make it even more difficult for this group to get the referrals that they needed to access additional services, such as mental health supports. Another participant pointed out that there were major wait times in settings with fewer barriers:

*“Community health centers have very good service, they have interpreters there, they can be assisted by nurses who can refer them to the doctor so they can access mental health. But there’s a waiting list of three, four, five months.”*

Service providers described related challenges to accessing healthcare. For example, an additional concern was that once a refugee claimant is granted status, they lose coverage under the IFHP and are transferred to Ontario Health Insurance Program (OHIP), which does not provide coverage for mental health support. As a result, users must either discontinue their treatment or pay out of pocket for continued care, which many are unable to afford.

Some service providers pointed out that one option for service users has been to access online therapy from professionals based outside of Canada, usually in their countries of origin, where therapy is often more affordable and conducted in their native language. One service user pointed out that a limitation of accessing foreign-based online therapy, is that unlike therapists based in the GTA, these providers are unable to connect users to emergency services (e.g., shelter services, supports for intimate partner violence) if needed. These examples highlight a larger problem of discrimination and other challenges faced by refugees in the healthcare system.

In light of the current pandemic and recovery efforts, service providers emphasized the importance of expanding mental health coverage under OHIP, one provider expressed this as follows:

*“My dream is that mental health services will be approved, will be OHIP covered, because there are lots of private psychotherapists and it’s great, but the fees are not accessible. So having some funding from government will be a way to just make things better not only for Latin Americans, I’ll say for all. We are in a mental health crisis at the moment...So we need to put some services in place just to recover because it’s not only the physical, but also the emotional, and how the emotional has a huge impact.”*

Like those who described their personal experiences within the healthcare system, service provider participants identified numerous barriers to accessing care for Latin Americans with refugee status despite having coverage under the IFHP.

## Barriers to health care access – Uninsured Latin Americans

Service provider participants also explained that Latin Americans who did not have OHIP encountered obstacles when it came to accessing healthcare in Toronto. For example, fear of deportation or separation from family is a significant barrier that can prevent non-status Latin Americans from seeking medical care or testing at healthcare centers. These quotes illustrate how this fear often prevented individuals from receiving the medical attention they needed:

*“The other thing was also the fear that many of these people were afraid to come and get tested, because in my experience, many of these people were undocumented and were afraid to come and register at the health center [thinking] that the health system was going to report them to the immigration system. It was very difficult to explain to them that medical records are private, that the hospital cannot share those results and cannot even share the demographic information of these individuals.”*

*“The lack of information [about the system] experienced by newly arrived people, who do not speak English and who are afraid of being deported, makes it very difficult for them to access health care.”*

*“There’s a fear of going to service providers, especially if they don’t have immigration status. And I just feel that they’re not like major users of the healthcare system... Yeah, I think that’s one of the big problems is that they have to be in the system in order to, you know, be able to get information.”*

Another service provider shared an example about a Mexican mother who delayed bringing her sick child to the hospital for ten days due to fear of being deported. The mother’s initial fear and lack of knowledge about the healthcare system presented a significant obstacle to accessing care:

*“[The mother] waited 10 days to come to the hospital, the child was very sick...[she] was very afraid to come [to the hospital] and it took me a lot of work to send her to the emergency room because she just wanted [to know what the child had]...Oh, and it took me a lot of work to get someone who spoke Spanish in the emergency room to receive them and take care of them...Fortunately the child was attended to and all services were provided... [as a result of] the decision made by the Government at that time not to charge anyone for medical care.”*

The provider eventually referred the mother to emergency services and arranged for translation support during the hospitalization so that the child could receive necessary medical attention. According to the service provider, the government’s temporary measure of extending healthcare to uninsured residents during the pandemic was instrumental in the child’s hospitalization and access to care.

Overall, these barriers have the potential to have a tremendous impact on the health of Latin Americans with precarious status who may avoid seeking medical care until their condition is more serious and harder to treat. As one service provider shared, they may arrive at the hospital with conditions that could have been prevented:

*“They arrive late and when I say late, they arrive with stage three cancer or uncontrolled diabetes, which could have been caught with preventive care. Perhaps they have reached a level of diabetes that can no longer be prevented. Then, preventive healthcare is key and all of this is lost when the person does not reach the healthcare system in time.”*

Most service providers raised the issue of precarious immigration status and the social vulnerability of this group due to the numerous contextual factors including substantial barriers to accessing health care services. These vulnerabilities and barriers to care had the impact of greatly compromising the health of this group in many cases discussed.

## DISCUSSION

The findings from this research revealed specific challenges and barriers to healthcare experienced by Latin Americans in Toronto during the pandemic. The following section addresses these in more detail, focusing on: the impact of informal caregiving responsibilities, digital inequities, the lack of Spanish language services as a significant barrier to healthcare access, and the barriers experienced by individuals with precarious immigration status. These issues are examined in light of previous research on the broader population and on experiences of racialized and immigrant communities. Some pathways forward are suggested to address these challenges.

### INFORMAL CAREGIVERS' HEALTH AND WELL-BEING

The results of this research demonstrate that participants struggled with their informal caregiving responsibilities and in many cases this had a negative impact on their health and well-being. The COVID-19 pandemic has had a significant impact on caregivers, especially women and mothers who have taken on a disproportionate share of these responsibilities.<sup>46</sup> Caregiver participants described how the lockdown measures early on in the pandemic forced them to assume additional responsibilities with little or no support.

Many caregivers described feeling lonely, isolated, and overwhelmed. These findings echo emerging research on caregiver experiences more broadly. Statistics from 2020 reveal that in Ontario almost half (47%) of caregivers were dealing with the anxiety and stress of care recipients due to COVID-19 and the associated restrictions.<sup>47</sup> Moreover, over three-quarters (77%) of those caring for individuals with mental health issues or addiction found it challenging to access mental health support for the person they were caring for.<sup>48</sup>

By 2022, roughly one-third of caregivers in Ontario were spending at least 10 hours a week providing physical or emotional support to someone in their care.<sup>49</sup> While this figure surged dramatically during the pandemic, it did not substantially decrease with the re-opening of community programs and services.<sup>50</sup> Additionally, many working caregivers worry about losing their jobs due to their caregiving responsibilities, and report worsened mental health since the peak of the pandemic.<sup>51</sup>

Research from the pandemic shows that unpaid caregivers in Canada take on financial risk related to the caregiving role (e.g., loss of work or care related costs) and better support

programs are needed to mitigate negative health impacts.<sup>52</sup> Canada introduced a pandemic income support program for caregivers throughout the pandemic (Canadian Recovery Caregiving Benefit) in 2020.<sup>53</sup> This policy response to support caregivers was discontinued in 2022.

Research suggests that caregiving needs have not declined since the onset of the pandemic and there are reports from other jurisdictions that long COVID has greatly increased caregiver burden for some families.<sup>54</sup> Post-pandemic policies must recognize the value of the everyday unpaid work of those caring for family and friends by providing sufficient financial support for those who are unable to work or who take on other financial risks due to their caregiving responsibilities. To ensure equity, these income support programs should be universal and available to all who need them regardless of their employment status at the time of application.<sup>55</sup>

An equity-based analysis (examining gender and other sociodemographic factors) of relevant support programs and policies should also be considered. For example, women who take time off work for caregiving are often penalized financially (e.g., through reduced pension fund contributions) and thus are more likely to live in poverty. Additionally, comprehensive caregiver support programs that are culturally appropriate must be established to provide respite care, counseling services, and other forms of support to assist caregivers in addressing mental health challenges and overall wellbeing.

## **DIGITAL EQUITY AND ACCESS TO ONLINE HEALTH AND MENTAL HEALTH SERVICES**

The COVID-19 pandemic accelerated the shift towards online service delivery and virtual care,<sup>56</sup> revealing pre-existing disparities in technology access and exacerbating digital divides.<sup>57</sup> As described by service providers in this study, Latin Americans faced obstacles accessing essential services online such as counseling and mental health therapy, especially those unfamiliar with navigating online platforms and facing language barriers. Lack of technology and access to devices as well as a lack of private spaces for counseling sessions also posed significant obstacles. These accounts highlight the connection between digital equity and larger economic inequalities and access to technological infrastructure.

Early in the pandemic a survey was conducted in Toronto to assess digital accessibility.<sup>58</sup> The survey revealed that a significant proportion of households in Toronto were concerned about their ability to pay for home internet and cell phone bills. Gaps in internet quality and affordability were found, along the lines of income, age and race. The highest levels of concern were among residents from low-income backgrounds, newcomers, single-parent households, and individuals from racialized communities.<sup>59</sup> Specifically, Latin American, South Asian, Black, and Southeast Asian respondents expressed greater concern about their ability to pay. Moreover, fifteen percent of households earning less than \$20,000 and twenty percent of individuals aged 60 and older did not own a smartphone.<sup>60</sup>

Although some health services have transitioned back to in-person delivery since the



pandemic, virtual care remains a reality and there is a need to assess inequities in access to all modes of providing care. This would include looking at how digital inequities might impact specific sub-groups, such as those who are uninsured and no longer have healthcare coverage in Ontario or those who require Spanish language services. Sustainable plans for virtual care services must consider economic disparities and the realities of communities with inequitable access to technologies. Ignoring this context will perpetuate challenges in the delivery of virtual care. This includes examining the potential challenges and benefits from being able to move between in-person and virtual services depending on an individual's context.

The literature on health equity and virtual care recommends three important lines of action.<sup>61</sup> First, it is important for policymakers and governments to invest in internet access and digital devices for those without access to ensure their participation in virtual healthcare. Second, health systems and stakeholders should develop clear digital equity-focused plans and provide effective training for healthcare providers to deliver virtual care in an equitable manner. Third, organizations need to invest in health equity organizational capacity, including developing anti-racism and anti-oppression knowledge and capacity within healthcare organizations that provide virtual care.<sup>62</sup>

## ACCESS TO SPANISH LANGUAGE SERVICES

This research highlights the lack of Spanish language services as a substantial obstacle to accessing healthcare in Toronto. The issue of language barriers in access to care is an ongoing challenge in Canada and Ontario.<sup>63</sup> Language issues are often more pronounced for newer immigrants and contribute to inequities in access to care.<sup>64</sup> While an individual may be proficient in everyday use of the official languages, fluency is often more limited in healthcare interactions because of factors such as the technical features of the language or different cultural contexts and understandings.<sup>65</sup> Healthcare services in Canada have been observed to lack consistent linguistically competent care.<sup>66</sup>

There is evidence that the lack of access to health care services in languages other than English and French impacts quality of care negatively,<sup>67</sup> and language barriers intersect with others for underserved communities in Canada, such as racial discrimination or lack of cultural safety.<sup>68</sup>

Pre-existing issues around language and inequitable access to healthcare may have been amplified during the pandemic.<sup>69</sup> Inequities in access to information about relevant health services (e.g., vaccines), may have contributed to inequitable outcomes for immigrant and other groups.<sup>70</sup> Lower rates of COVID-19 testing were observed for recent immigrants and refugees in Ontario in the first year of the pandemic and a lack of English or French language ability was associated with lower testing.<sup>71</sup> Virtual care may also be more difficult for patients without official language fluency,<sup>72</sup> but also could increase the availability of providers with other language skills.<sup>73</sup>

There are significant gaps in formal translation policy in Ontario's healthcare system. Although healthcare settings have an imperative to remove barriers to care by offering

direct services or interpretation in languages other than English or French, the enactment of and follow up on these standards is inconsistent. There is a history of advocacy to the federal and provincial governments to improve translation and related language services to increase equity and non-discrimination in healthcare access.<sup>74</sup> This has included calls for consistent, standardized services through a centralized language interpretation system in Ontario, similar to those funded by other provinces like BC.<sup>75</sup> Unfortunately, there has been a lack of action to implement and enforce changes over the last decade.

As the findings from this research highlight, diverse language skills/capacity often exist at the community level in health and social service organizations, including the non-profit Community Health Centres. Greater investment in already existing public community-based networks to increase equitable access to Spanish language information and services may be an efficient policy approach.

Others have identified policy options for reducing language barriers to healthcare access, including increasing the number of professional interpreters within the system and education of healthcare providers on the use of interpreters, facilitating enrollment of priority-language speaking individuals in healthcare programs, and exploring whether international graduates could complete requirements to practice in areas where there are greater language needs.<sup>76</sup>

## UNINSURED AND THOSE WITH PRECARIOUS STATUS

Study participants highlighted the difficulties faced by refugee claimants and non-insured residents during the pandemic, including limited access to healthcare. Refugee claimants faced challenges accessing healthcare through the IFHP due to their unfamiliarity with the healthcare system and the lack of information about the IFHP among both providers and users. Language barriers or literacy issues further exacerbated the existing barriers to these kinds of programs. Lack of consistency, confusion around the application of the program, and the denial of healthcare to eligible claimants due to administrative issues have been documented since at least 2012.<sup>77,78</sup>

People who are uninsured also faced considerable barriers to accessing healthcare and related supports in Canada. During the pandemic, non-status migrants were ineligible to receive pandemic-related income support programs such as the Canadian Emergency Response Benefit (CERB) or general government worker support, which led them to continue working during the lockdown and put them at higher risk of contracting COVID, as participants discussed. This research suggests that a more in-depth analysis of the ways that different federal and provincial immigration-related policies work together to undermine health and well-being is also needed.

In 2020, the Ontario government made healthcare accessible to all, regardless of immigration status, under the Physician and Hospital Services for Uninsured Persons Program. Although our findings suggest the need for greater awareness about this service access within communities, the program addressed a crucial gap in Ontario health coverage. Early research suggests improved healthcare experiences for uninsured patients

in Toronto since its inception.<sup>79,80</sup> The provincial government stopped funding this program as of April 1, 2023.<sup>81</sup> The discontinuation of this and similar provincial initiatives (e.g., paid sick days)<sup>82</sup> is a regressive step that undermines support for marginalized groups, including temporary or precarious workers, and will propagate health inequities.

In a recent report<sup>83</sup> the Health Network for Uninsured Clients (HNUC) recommends making the Physician and Hospital Services for Uninsured Persons Program permanent and standardizing it across hospitals, including establishing clearer billing processes and increasing awareness of the program's availability. To enhance access to primary healthcare for uninsured individuals the report also recommends increasing funding for community health centers and uninsured health clinics, as well as educating healthcare professionals about healthcare options available to uninsured people. As a Sanctuary City,<sup>84,85</sup> Toronto has a responsibility to ensure that all individuals, including non-status migrants, have access to essential services and support programs without fear of discrimination or deportation.<sup>iv</sup>

To improve access to primary healthcare services, research also suggests collaboration between local non-medical immigrant settlement organizations and healthcare partners.<sup>86</sup> These organizations have a unique proximity to immigrant populations and can facilitate access by connecting users with health care services and providers, promoting immigrant health, delivering educational programs, and engaging in community mobilization and advocacy initiatives aimed at improving healthcare access. Incorporating non-medical immigrant settlement organizations into healthcare planning and service delivery can potentially address the healthcare needs of immigrant communities, including refugee claimants and non-insured individuals.

## LIMITATIONS OF THE NEEDS ASSESSMENT

While this study offers valuable insights into the experiences of Spanish-speaking Latin Americans in Toronto, it is important to consider certain limitations when interpreting the findings.

One significant limitation of this study is the lack of participation from Black, non-binary, and other LGBTQ2S+ identified individuals within the sample. This highlights the necessity for future research in this area to increase representation of these groups. Furthermore, the interviews were conducted exclusively in Spanish, which could have posed a language barrier for some Latin Americans who speak other languages (e.g. Indigenous Languages, French, Portuguese, etc.). This limitation means that the perspectives of individuals who do not speak Spanish may have been excluded from the research. Additionally, the recruitment process, which relied on networks, may have resulted in the exclusion of individuals who are more socially isolated within the Latin American communities, leading to potential gaps in the findings and limiting the generalizability of the results to the broader population.

Another important limitation is the small sample size of individuals with precarious status and the exclusion of migrant agricultural workers in the study. While service providers

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iv Sanctuary cities aim to safeguard the rights of non-status migrants by enabling their access to certain municipal programs and services without the risk of arrest, detention, or deportation (Paquet et al., 2022).



provided detailed descriptions of some of the experiences of Latin Americans with precarious status, a larger sample size of individuals with lived experience in this area is needed to develop a more comprehensive understanding of the challenges faced by this group. Non-insured individuals, in particular, face significant vulnerabilities and barriers to accessing essential services. Given that governmental agencies do not collect data on this group, it becomes crucial to collect more first-hand accounts to gain a more comprehensive understanding of their situations. Similarly, research on the working conditions of migrant agricultural workers remains insufficient.

Lastly, it is important to note that this is a snapshot study reflecting people's experiences at a specific point in time. Some complexities of dealing with COVID-19 may have been most pronounced at other time points.

## CONCLUSION

Findings from this needs assessment illustrate the disproportionate impact of COVID-19 on Latin American communities in Toronto. The report highlights some of the challenges faced by this population as a result of pre-existing health, social, and economic inequalities in the city. Language barriers and limited access to essential health and social services have made this population more vulnerable to the virus. The report emphasizes the need for culturally sensitive and comprehensive healthcare services and supports to address their physical and mental health needs, including support for caregivers, bridging the digital divide to improve access to virtual care services, and addressing challenges faced by immigrants with precarious status.

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Canadian Mental  
Health Association  
Toronto

**West Office**

700 Lawrence Ave W,  
Suite #480 Toronto,  
ON M6A 3B4

**East Office**

1200 Markham Rd,  
Suite #500 Scarborough,  
ON M1H 3C3

416-789-7957  
[cmhato.org](http://cmhato.org)  
[info@cmhato.org](mailto:info@cmhato.org)



201 Gerrard Street. E.  
Toronto, ON M5A 2E7

416-972-1010  
[wellesleyinstitute.com](http://wellesleyinstitute.com)



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