FROM BARRIERS TO SOLUTIONS -

TD Community Health Solutions Research Grant

A COMMUNITY-BASED STUDY

of Healthcare Access for Reproductive-Age Newcomer Women in Thorncliffe Park and Flemingdon Park

Exploring Healthcare Access, and Community-Led Recommendations in East Toronto

From Barriers to Solutions: A Community-Based Study of Healthcare Access for Reproductive-Age Newcomer Women in Thorncliffe Park and Flemingdon Park

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We are deeply grateful to our partner organizations in the Flemingdon and Thorncliffe communities for their invaluable support in data collection and for helping us build meaningful connections with local residents.

COMMUNITY PARTNERS

Flemingdon Health Centre (FHC)

Health Access Thorncliffe Park (HATP)

The Neighbourhood Organization TNO

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INTRODUCTION

Canada's healthcare system is currently under significant strain, with accessibility challenges and resource limitations affecting communities across the country. Approximately one in five Canadians lacks a regular family physician, and fewer than half are able to secure timely appointments with primary care providers.[1] These access gaps disproportionately affect marginalized populations, including newcomer communities, who often encounter systemic barriers such as language limitations, cultural mismatches, and a lack of awareness of available services.[2]

At the provincial level, Ontario's healthcare system is under immense pressure due to rising demands, physician shortages, and an overstretched primary care network. Findings from the OurCare initiative, a national research effort led by Dr. Tara Kiran, highlight significant inequities in primary care access, with many Ontarians unable to find a family doctor or receive timely, coordinated care.[3] The study emphasizes the need for community-driven, patient-centered approaches to healthcare reform, particularly for historically underserved groups such as newcomers and low-income families.[4] Concurrently, Ontario's political landscape is shifting, with influential figures like Dr. Jane Philpott, former federal Minister of Health and a leading advocate for primary care transformation, pushing for systemic reforms. Dr. Philpott's work on the Primary Care Action Plan emphasizes equitable, inclusive, and sustainable healthcare solutions that prioritize marginalized communities.[5]

Locally, Thorncliffe Park and Flemingdon Park, two of Toronto's most diverse neighborhoods, exemplify the challenges faced by newcomer communities. Often referred to as "arrival cities," they serve as transitional spaces for new migrants and are emerging as future

centers of economic development.[6] These neighborhoods are home to some of the highest proportions of immigrants in the city. According to the 2016 Census, 63.7% of Thorncliffe Park residents and 64% of Flemingdon Park residents were born outside of Canada. Additionally, a majority of residents (73.9% in Thorncliffe Park and 69.5% in Flemingdon Park) report a mother tongue other than English or French.[7,8] These communities are characterized by high-density rental apartment living, a large youth population, and household incomes lower than the Toronto average. Thorncliffe Park, in particular, is one of Toronto's fastest-growing immigrant communities, facing significant barriers in accessing health services and experiencing poor health outcomes.[9] Recent developments, such as the construction of the Ontario Line Rail Yard, have further impacted these communities, leading to the displacement of approximately 700 jobs and 57 businesses.[10] These changes exacerbate existing socio-economic challenges and therefore, highlight the need for a thorough understanding of the community's healthcare needs.

Despite these challenges, there remains a critical gap in community-engaged research that centers immigrant communities in discussions about barriers to solutions for primary care access.[11-12] While existing East Toronto health assessments (Taylor-Massey Oakridge) have mapped general barriers to healthcare access,[13] none have specifically examined how systemic challenges uniquely affect newcomer women. This study addresses a gap by centering reproductive-age women's experiences in Thorncliffe Park and Flemingdon Park to inform gender-sensitive healthcare solutions. This absence of perspective is especially concerning in a multicultural society like Canada, where a one-size-fits-all approach to healthcare is often ineffective.[14,15] Although the demographic profiles of these neighborhoods align with broader East Toronto trends, Thorncliffe Park and Flemingdon Park offer a distinct case study in how rapid urban development, infrastructure changes, and concentrated newcomer populations can intensify healthcare access

barriers. Through direct engagement with local women, this study supports Ontario's health equity goals by generating gender-responsive, place-based policy recommendations for immigrant communities experiencing rapid growth.

OBJECTIVE

This study aims to provide a current snapshot of healthcare access experienced by newcomer women of reproductive age in the Thorncliffe Park and Flemingdon Park communities. Its objective is to identify existing gaps in services and supports, with the goal of informing culturally appropriate solutions to address the healthcare needs of this population. This work directly supports Ontario's broader Quality Improvement priorities [16] and aligns with the Quintuple Aim framework,[17] particularly in advancing health equity. Findings from this study aim to inform community-driven solutions to alleviate pressures on Ontario's increasingly strained healthcare system.

METHODOLOGY

This study applied a Community-Based Participatory Research (CBPR)[18] and Integrated Knowledge Translation (iKT)[19] framework to identify the healthcare service needs and access barriers of reproductive-age newcomer women in the Thorncliffe Park and Flemingdon Park neighborhoods of Toronto. A cross-sectional mixed-methods design was used to gather both quantitative and qualitative data.

Between March 2024 and January 2025, a total of 201 responses were collected through the community survey. As the study focused on reproductive-age women (defined as 18–52 years), responses from individuals outside this age range were excluded, resulting in a final analytic sample of 180 participants.

Eligibility was limited to self-identified newcomer women, defined as those who had arrived in Canada within the past 10 years, and were able to provide informed consent. While focus group and interview participants were formally screened for eligibility, online survey inclusion relied on self-identification. This inclusive approach was chosen to reflect the extended and varied nature of settlement challenges that may persist beyond formal immigration timelines, though it may have introduced sample variability.

To promote accessibility, the survey was offered in both online and paper formats, and included both closed- and open-ended questions. The questionnaire covered three main domains: participant demographics, barriers to healthcare access, and service needs. Six focus group discussions were also conducted in Pashto, Dari, Urdu, Hindi, Farsi, Arabic, and Tigrinya, led by trained multilingual facilitators to elicit deeper insight into cultural and systemic barriers.[20] Additional one-on-one interviews were supported by interpreters in other common languages (e.g., Slovak), specifically for participants unable to complete the survey independently.

The study was implemented in partnership with Health Access Thorncliffe Park (HATP) and The Neighbourhood Organization (TNO). Community outreach strategies included distributing flyers, promoting the survey in WhatsApp-community group, and engaging Community Health Ambassadors and volunteers to support participation. All participants received a modest incentive (CAD $20–$25) for their time for completing the survey. Ethics approval was obtained from the Michael Garron Hospital Research Ethics Board.

DATA ANALYSIS

Quantitative data were analyzed descriptively using Microsoft Excel. Responses were grouped into thematic domains based on the structure of the survey, including demographics, challenges and barriers to healthcare access, and service needs. Frequencies and percentages were used to summarize responses and identify prominent service access challenges.

Some questions were introduced partway through data collection in response to early participant feedback. For example: Notably:

- A question on language preference and language-related barriers was added later and received responses from 132 participants.
- A question about whether respondents had a family physician or nurse practitioner and whether they accessed care during urgent needs was answered by 152 participants.

These additions reflected important themes raised during early qualitative input but resulted in smaller sample sizes for those specific items. Findings are interpreted accordingly.

To assess the level of consensus around the importance of different services, standard deviation (SD) was used as an indicator of response variability across 14 services. SD values ranged from 1.00 to 1.45 and were divided into three categories: range (0.45), services were categorized into three levels of variability:

- Low Variability: SD < 1.10, indicating high consensus among respondents.
- Moderate Variability: 1.10 ≤ SD < 1.25, reflecting some divergence in opinion.
- High Variability: SD ≥ 1.25, suggesting substantial variability or disagreement.

These categories allowed meaningful interpretation of which services were universally prioritized and which were subject to divergent views, potentially due to differences in cultural relevance, familiarity, or unmet needs.

Although no formal coding software was used, responses from focus groups and open- ended survey questions were reviewed thematically.[21] Thematic analysis was guided by the structure of the survey itself, organizing responses into three primary domains: participant demographics, barriers to healthcare access, and perceived service needs. These themes were used to contextualize and triangulate the quantitative results, offering a more comprehensive understanding of participants' healthcare access experiences.

LIMITATIONS

Despite efforts to design an inclusive and community-centered study, several limitations must be acknowledged. First, self-selection bias may have influenced participation, with individuals experiencing greater healthcare concerns more likely to respond. Language and digital access

barriers may have excluded some subgroups, particularly for the online version of the survey. Although interpreters were used to support comprehension, potential translation inconsistencies may have affected how participants understood specific questions.

No formal qualitative coding was applied to focus group transcripts, limiting the depth of narrative analysis. Additionally, the geographic specificity of the sample constrains the generalizability of findings to other newcomer populations. Finally, while the financial incentive was modest, it may have influenced participation, potentially contributing to response bias.

RESULTS

A total of 201 responses were collected through the community survey between March 2024 and January 2025. After excluding individuals outside the target age range of 18 to 52 years, the final analytic sample consisted of 180 reproductive-age newcomer women.

The findings are organized according to the three core domains explored in the survey: participant demographics, healthcare access challenges, and identified service needs.

Demographics

The majority of respondents identified as female (96.11%), with a small proportion identifying as transgender (0.56%) and non-binary (0.56%) individuals. Age distribution was varied, with 42.22% aged 18–30, 38.89% aged 31–40, and 18.89% aged 41–50.

Most participants (72.78%) were insured under the Ontario Health Insurance Plan (OHIP), while 1.67% were covered by the Interim Federal Health Program (IFHP), and 12.22% reported no health insurance. A small percentage (8.89%) chose not to disclose their insurance status.

In terms of marital status, 63.89% were married, 25.56% were single, and 3.89% were separated or divorced.

The surveyed population demonstrated significant ethnocultural and linguistic diversity.

The sample demonstrated substantial ethnocultural and linguistic diversity. Nearly half (48.33%) identified as South Asian (including Indian, Pakistani, and Afghan backgrounds), followed by 18.89% identifying as Caucasian or Slovak, and 11.11% as Black or African descent. Other groups including Arab, Hispanic/Latino, East Asian, and Southeast Asian, each comprised under 10% of the sample.

Respondents reported speaking 18 different languages. The most common were Urdu (19.70%), Slovak (19.70%), English (15.15%), Pashto (12.88%), and Arabic (11.36%). Additional languages included Dari, Tigre, Hindi, and Spanish, as well as languages spoken by smaller numbers (e.g., Turkish, Tamil, Ilocano, Swahili). This broad linguistic spectrum reflects the complex cultural makeup of the community.

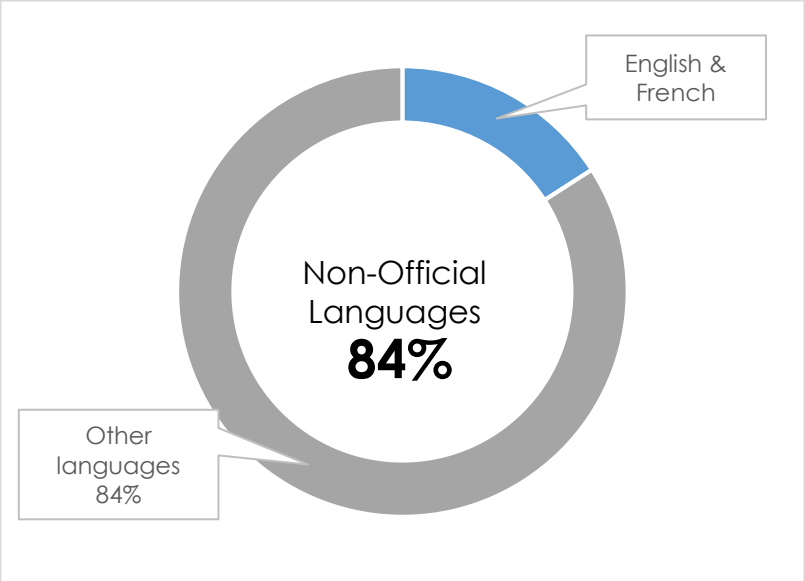


Figure 1: Languages spoken among respondents; (n=132)

Indicators of social vulnerability were prominent. Low educational attainment was common, with 11.11% reporting no formal education and 25% completing some high school without a diploma. Most respondents (87%) had one to three dependents, and 22% cared for four or more, highlighting caregiving pressures. Employment challenges were also notable, with 53.89% reporting being unemployed or acting as unpaid caregivers.

Chronic health conditions were reported by 12.78% of respondents, including asthma, diabetes, hypertension, fibromyalgia, Graves' disease, myasthenia gravis, migraines, sciatica, and Raynaud's phenomenon. Some participants also reported blindness and wheelchair use, indicating a range of physical and neurological impairments in the sample.

Challenges

Participants reported varied frequencies of healthcare access: 33.89% sought care occasionally (every few months), 25% accessed care more frequently (every month or two), and 22.22% visited healthcare providers only once or twice a year. A smaller group (13.89%) rarely or never sought care. (Fig 2)

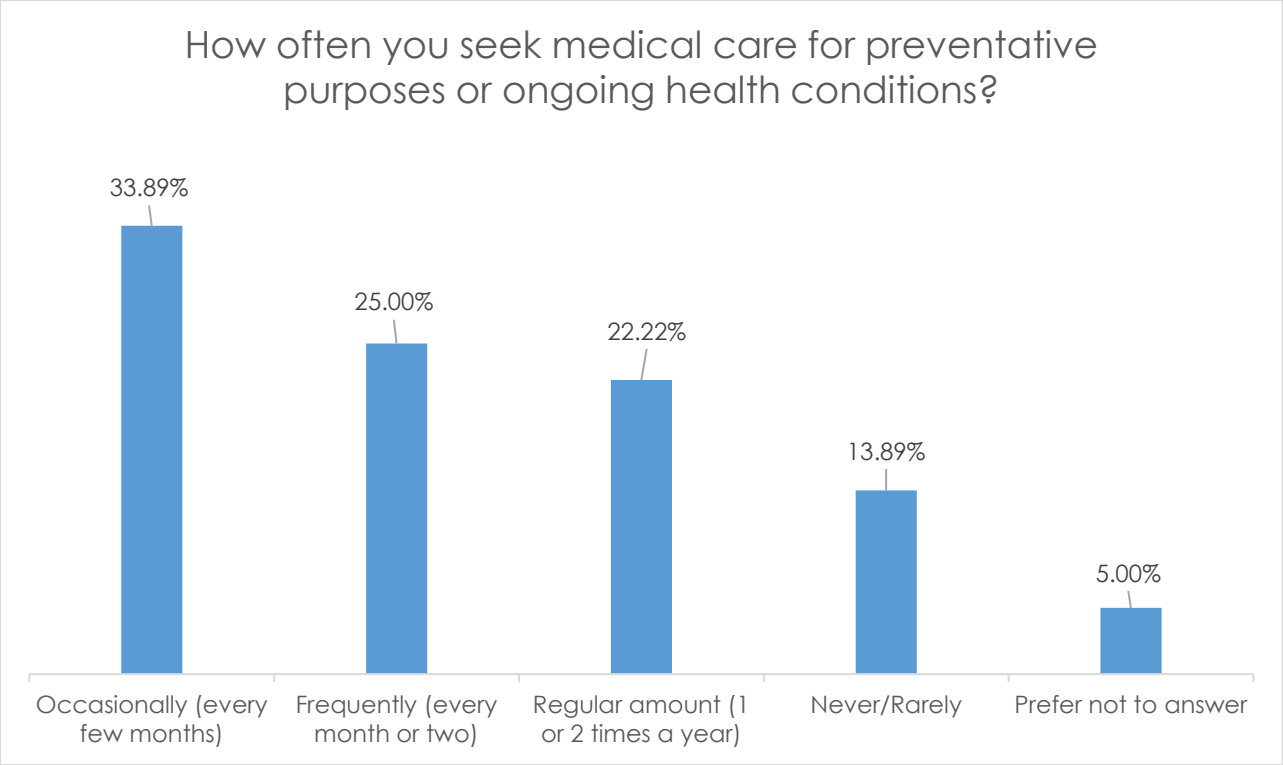


Figure 2: Frequency of seeking medical care

The most commonly cited barriers to access included limited service availability (34.44%), language barriers (26.11%), and transportation logistics (15.56%). Notably, 74.44% of participants were unaware of any financial assistance programs that could support healthcare access.

In terms of experiences with stigma and discrimination, 80.34% reported no negative experiences, whereas 8.55% indicated they had faced stigma, with the remainder preferring not to answer. Additionally, 22.5% noted that cultural or religious factors influenced their ability to access health and social services. Focus group discussions elaborated on these findings, with participants recounting experiences of dismissive remarks, judgmental attitudes, or microaggressions, particularly in the context of language barriers or cultural dress. Several women expressed frustration with being treated as just another number, with providers often addressing only one issue per visit. These concerns were not limited to physicians but extended to other healthcare-related staff, highlighting a broader issue of cultural insensitivity across care settings. Cultural and religious factors influenced access for 22.5% of respondents, particularly in relation to a preference for female providers for pregnancy, gynecology, and postpartum care.

In terms of system navigation, 51.25% reported no difficulty identifying suitable healthcare or social services. However, many others cited barriers such as unavailable appointments, clinic waitlists, and lack of providers. While participants expressed general satisfaction with community-based services such as settlement supports, language classes, and parenting programs, they also reported feeling overwhelmed by scattered and inconsistent information. About 25% relied on online searches to find resources, while others depended on community events or word of mouth, suggesting fragmented and informal pathways to care.

Service Needs

The ranking of services by participants offers valuable insights into the healthcare and social service priorities of the community. Table 1 summarizes the mean importance scores of 14 services, alongside their standard deviations (SD) and 95% confidence intervals.

Participants rated the perceived importance of each service on a 5-point scale, where 1 indicated lowest importance and 5 indicated highest importance. Rankings were based on mean importance scores, with standard deviation used to assess the level of consensus among participants.

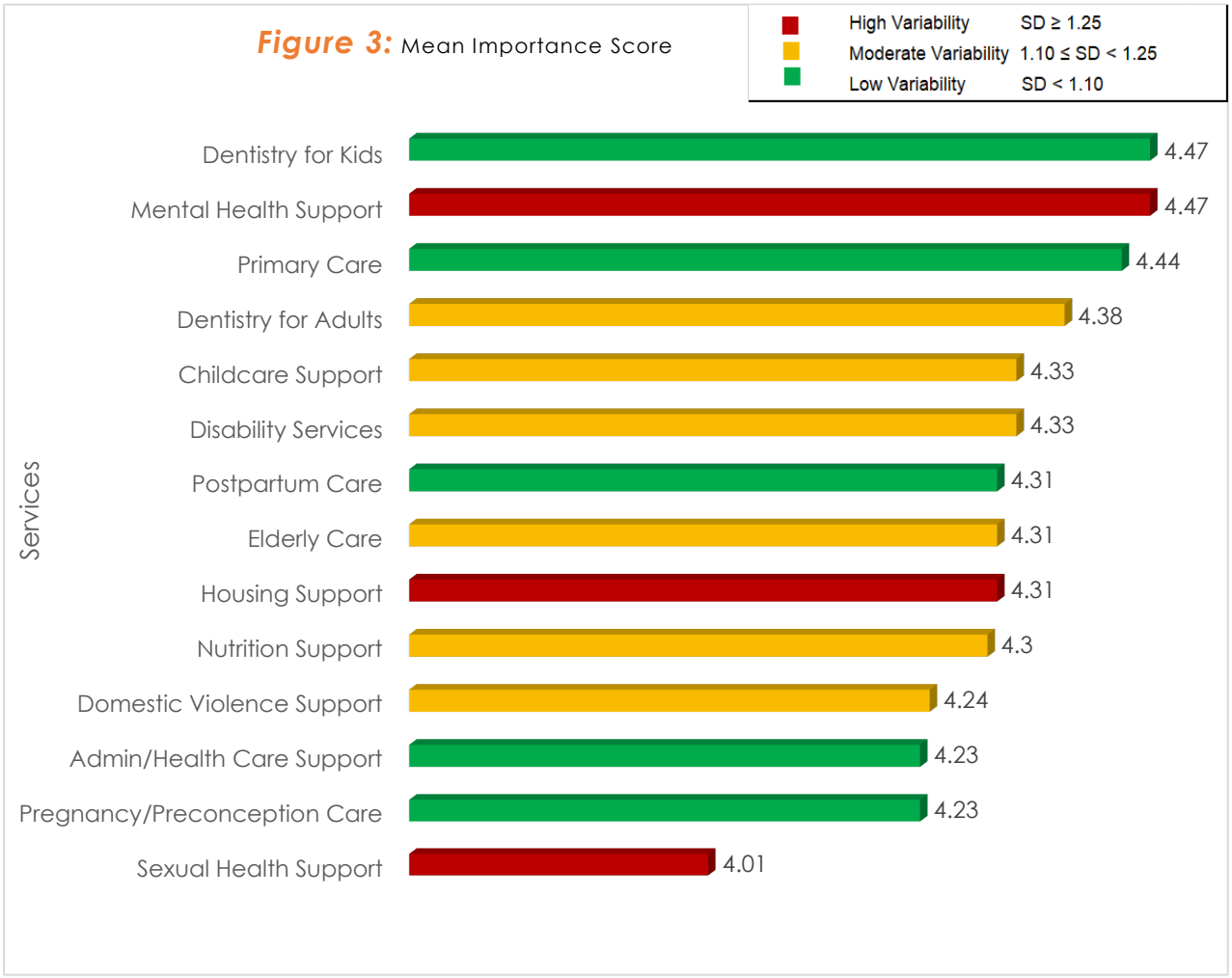
Rank	Services	Mean Importance Score	SD	Variability
1	Dentistry for Kids	4.47	1	Low
2	Mental Health Support	4.47	1.45	High
3	Primary Care	4.44	1.05	Low
4	Dentistry for Adults	4.38	1.12	Moderate
5	Childcare Support	4.33	1.18	Moderate
6	Disability Services	4.33	1.28	High
7	Postpartum Care	4.31	1.06	Low
8	Elderly Care	4.31	1.1	Moderate
9	Housing Support	4.31	1.35	High
10	Nutrition Support	4.3	1.12	Moderate
11	Domestic Violence Support	4.24	1.19	Moderate
12	Admin/Health Care Support	4.23	1.05	Low
13	Pregnancy/Preconception Care	4.23	1.09	Low
14	Sexual Health Support	4.01	1.38	High

Table 1: Ranking of service importance by mean score and variability and 95% confidence intervals

The standard deviation (SD) values across the 14 services ranged from 1.00 to 1.45. For interpretation, the range was divided into three equal intervals using a tertile-based approach (as described in the Methodology). This allowed for consistent classification of variability.

The highest rated services were: (Figure 3)

- Dentistry for Kids (Mean = 4.47, SD = 1.00; Low variability)
- Mental Health Support (Mean = 4.47, SD = 1.45; High variability)
- Primary Care (Mean = 4.44, SD = 1.05; Low variability)



While the first and third services showed strong consensus, mental health support exhibited the greatest variability, possibly reflecting cultural stigma, differing mental health literacy, or inconsistent service availability.

Moderately rated services with relatively high consistency included Postpartum Care, Admin/Health Care Support, and Pregnancy/Preconception Care. These services had slightly lower mean scores but low SDs, suggesting shared perceptions of their importance across the sample.

Sexual Health Support received the lowest average score (4.01) and showed high variability (SD = 1.38), indicating polarized views, likely shaped by cultural taboos, stigma, or limited exposure to such services.

DISCUSSION

This section interprets the study findings through three interconnected domains: demographic and community composition, barriers to healthcare access, and service needs. Drawing on both quantitative results and qualitative insights, we critically examine how intersecting social determinants, systemic constraints, and cultural dynamics shape healthcare access for reproductive-age newcomer women in East Toronto. The discussion integrates relevant literature and considers implications for health equity, service design, and policy reform.

Demographics: *Understanding Community Composition*

The demographic profile of participants highlights the deep ethnocultural and linguistic diversity of East Toronto's newcomer populations. While 21.9% of Canadians are foreign-born,[22] the proportion in Thorncliffe Park and Flemingdon Park far exceeds this national figure, with over 63% of residents in these neighborhoods born outside Canada.[7,8] This diversity was mirrored in our sample, where 48.33% identified as South Asian (Indian, Pakistani, Afghan), 18.89% as Caucasian/White/Slovak, and 11.11% as African American/Black, alongside smaller representation from Arab, Latino, Caribbean, and Southeast Asian groups.

Linguistic diversity was equally pronounced. Respondents reported speaking 18 different languages, with Urdu, Slovak, English, Pashto, and Arabic most frequently cited. This reinforces language as a critical axis of healthcare access, particularly in neighborhoods where English or French are not the primary languages spoken at home.

Beyond language, structural vulnerabilities were prominent. A considerable proportion of participants had limited formal education (11.11% had no schooling; 25% had some high school without diploma), were unemployed or unpaid caregivers (53.89%), and were managing caregiving responsibilities for multiple dependents (76.67% cared for at least one child or dependent). These intersecting factors constrain not only financial stability but also health literacy and service navigation, which are the key components of equitable access. Similar findings have been documented in studies of immigrant women in other high-inequity zones across Canada.[23–25]

Geographically, these communities are situated within Toronto's highest-scoring neighborhoods on the City of Toronto's Child and Family Inequities Index.[26] While integrated care models such as those piloted by East Toronto Health Partners (ETHP) offer promise, persistent service gaps remain. These findings underscore the importance of localized, culturally responsive, and structurally informed interventions to advance Ontario's health equity agenda.[27]

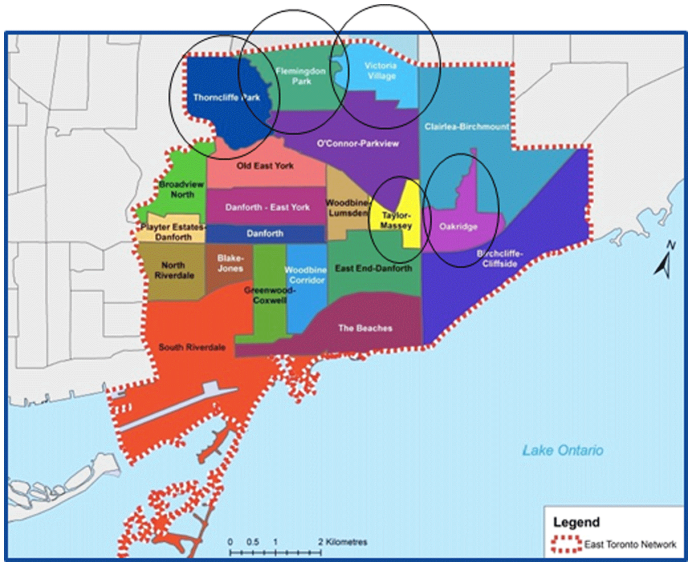


Figure 4: The East Toronto Health Partners (ETHP) neighborhood model approach to equitable care. Reprinted from East Toronto Health Partners: A neighborhood model approach to equitable care, by International Journal of Integrated Care, 2023, International Journal [27]

Challenges: *Understanding Barriers to Care*

Structural Barriers

Despite formal attachment to family doctors, walk-in clinics were the most accessed sites during urgent health episodes. Their appeal lay in flexibility, shorter waits, and local accessibility. Although 82.73% of respondents were rostered with a family physician, over one-third (33.55%) continued to use walk-in clinics or emergency departments, with 8.72% relying exclusively on the latter. This disconnect suggests that rostering alone does not guarantee meaningful access, particularly for women and newcomer populations.

Focus groups revealed that many mothers opted for walk-in clinics not by preference, but out of necessity due to inflexible appointment hours and feelings of judgment when seeking frequent care from regular providers. Many recalled accessing a local "respiratory clinic" opened during COVID-19, praising it for stroller accessibility and family-focused care. Participants expressed a strong desire for similar walk-in options year-round, unaware that fragmented care can lead to poorer long-term outcomes.

These findings echo broader critiques in the literature: rostering alone does not guarantee meaningful access, especially for racialized, low-income, and immigrant communities.[28–30] Research further confirms that users of walk-in clinics are more likely to require follow-up in emergency departments and face increased health risks compared to those consistently seen by a family physician. [31,32] Participants also noted that family physicians often limit appointments to one issue or one child per visit, leaving other urgent needs unaddressed. In contrast, Urgent Care Respiratory Clinics (UCCs) were praised for their integrated approach. Recent evaluations of

UCCs in Canada highlight their role in reducing emergency department burden and improving satisfaction, especially among families with recurring pediatric concerns. Recent evaluations of UCC models in Canada highlight their role in reducing emergency department burden and improving patient satisfaction, particularly among families managing multiple or recurring pediatric concerns. [33,34]

In East Toronto, this trend mirrors patterns identified by Access Alliance ((Taylor Massey Oakridge) but also adds new dimensions.[13] Participants emphasized that inaccessible clinic hours, lack of child-friendly services, and provider insensitivity discouraged them from seeking timely care.

Focus groups surfaced three interrelated challenges:

1. ## TEMPORAL INACCESSIBILITY:

   Several women cited conflicts between rigid clinic hours and caregiving responsibilities. One participant explained, *"They offer 9-to-5 appointments only, but who will watch my children that time when only my husband is working? I delay care until it becomes an emergency."*

2. ## CLINICAL CULTURAL INSENSITIVITY:

   Some women reported feeling judged or dismissed by providers, particularly for frequent child health concerns. As one mother shared: *"The doctor rolled his eyes when I brought my daughter for the third ear infection that month. Now I wait until her fever won't break before going."*

3. SERVICE INFRASTRUCTURE GAPS:

Many participants described access challenges that became especially burdensome in the winter, when walking with children and strollers became more difficult. One noted:

"When I am late for the appointment due to elevator delays of the high-rise rental building and 3 kids, I am told to rebook after a month."

Trust, Navigation and Health Literacy Gaps Challenges:

Although 50% of respondents reported satisfaction with services, 38.33% still relied on online searches to find health-related information, highlighting a disconnect between perceived satisfaction and actual access to coordinated care. Focus group discussions revealed that patients often expect physicians to help navigate the system, particularly in dealing with delayed administrative forms (e.g., financial, disability), securing community resources, and coordinating care. This places additional pressure on healthcare providers, many of whom lack the resources to offer navigation support. Recent literature emphasizes how health literacy limitations, unfamiliarity with healthcare procedures, and lack of formal navigation support reduce immigrants' effective engagement with services.[13,35]

Focus group participants emphasized the need for a dedicated patient helpdesk to support both patients and providers. Such a team would not only bridge the gap between clinical care and system logistics but also enhance trust, reduce inefficiencies, and enable more equitable access to care. This need was amplified by Edelman's (2024) findings on trust-building through hyper-local intermediaries.[36] The 2024 Edelman Trust Barometer's revelation of declining institutional trust in healthcare systems contextualizes our participants' reliance on informal networks, a phenomenon particularly pronounced among women who reported depending on children/friends for care navigation. This trust deficit exacerbates existing barriers in neighborhoods already facing systemic exclusion.

Transportation and Logistical challenges

Transportation was identified as another persistent barrier. Focus groups highlighted that missed appointments were often due to financial limitations, such as unaffordable transit fares, and the absence of navigation assistance for rescheduling inconvenient bookings. Many had to transfer buses multiple times due to the absence of a direct route to local hospitals and nearby specialist clinics. Recommended interventions included establishing direct transit routes or subsidized community shuttle services. Community-led transportation advocacy and policy reform have been shown to improve access for underserved populations.[37-39]

Mental health, Caregiver and Family Support Challenges

Despite the high significance placed on mental health, responses revealed notable variability in self-reported needs (SD = 1.45), potentially reflecting stigma or a lack of mental health literacy among immigrant women. This finding is consistent with recent Canadian research demonstrating how cultural stigma, silence around mental illness, and systemic under-resourcing limit access to mental healthcare for immigrant and racialized women. [40,41] Community-based, culturally tailored counseling and mental health literacy programs are needed to address these disparities.[42]

Participants emphasized the dual benefits of physical activity for both mental and physical well-being, but reported significant access barriers. Women described a lack of inclusive and affordable exercise spaces, including limited or no access to women-only gyms or fitness programs. For instance, only one co-ed gym was accessible, with a single hour per week allocated for women-only swimming. These findings align with research that emphasizes the need for private, gender-sensitive physical activity spaces to reduce cultural and religious barriers to participation.[43-45]

Additionally, childcare was identified as a critical determinant of healthcare access. Women noted that while childcare support was offered during language programs, it was often unavailable during healthcare services. This inconsistency led to lower engagement in health related group programs. On-site childcare during health promotion programs could substantially increase participation, mirroring findings that family support including reliable childcare is essential to enabling access to health services for immigrant families.[46,47]

Service Needs: *Understanding Shared and Divergent Priorities*

The ranked list of 14 services offers insight into both shared and divergent perceptions of importance among respondents. To interpret these results, services were categorized using both mean importance scores and standard deviation (SD) thresholds:

- **Low Variability (SD < 1.10):** High consensus: strong candidates for immediate investment
- **Moderate Variability (1.10 ≤ SD < 1.25):** Some divergence: may require stakeholder input and service redesign
- **High Variability (SD ≥ 1.25):** Polarized views: often signal stigma, systemic barriers, or informational gaps

Variability in service prioritization provides strategic insights rather than mere statistical details. It reveals where needs are consistently prioritized versus where they are contested, guiding efforts to build trust, enhance equity, and design culturally responsive solutions.

Services like Dentistry for Kids and Primary Care ranked highest, with low variability (SD < 1.10), reflecting widespread agreement on their importance. Participants emphasized the need for walk-in models that accommodate whole families, especially during colder months, underscoring the value of co-located, accessible care. This sentiment was echoed in the high rankings of Dentistry for Adults and Primary Care.

In contrast, Mental Health Support ranked second in mean importance but showed the highest variability (SD = 1.45), indicating divergent views. This may reflect cultural stigma, differing levels of mental health literacy, or unfamiliarity with the system, particularly among immigrant and racialized women. Similar patterns were seen with Disability Services and Housing Support, where high mean scores were paired with high variability, pointing to uneven access and fragmented experiences.

On the other end, services like Postpartum Care and Pregnancy/Preconception Care had lower rankings but showed low variability, suggesting consistent demand that may be under-recognized in broader system planning.

Notably, services such as Admin/Health Care Support and Childcare Support were not among the top in quantitative rankings but were frequently highlighted in qualitative responses as critical enablers of care, especially for women juggling caregiving roles. Their moderate-to-low variability reinforces their consistent, if understated, importance.

Ultimately, the variability metric surfaces underlying equity issues. High-variability services like Sexual Health, Mental Health, and Housing Support often correlated with themes of stigma,

mistrust, and navigation barriers. Integrating this understanding into planning allows for more tailored, person-centered, and equitable care models.

RECOMMENDATIONS

Based on the findings of this study, the following recommendations are proposed to enhance healthcare access and equity based on the Social Ecological Model framework described by the Centers for Disease Control and Prevention (CDC).[48]

1. Individual & Interpersonal Level

Establish a Centralized Multilingual Community Health Help Desk as a safe, trusted, first point of contact to bridge residents with local doctors and healthcare services. Key functions include:

Health System Navigation Support:

- Assist with healthcare appointment bookings, send reminders and directions, arrange escorts for complex cases, offer on-demand health information chats, and facilitate referrals, connect to supports available for Mental health, Caregiver and Family Support needs
- **Digital Access Assistance:** Support community members in navigating online health portals (e.g., hospital systems, appointment booking platforms), including translation services for healthcare documents.
- **Culturally Adapted Health Education:** Provide multilingual, culturally sensitive guidance on healthcare system use (e.g., when to visit a family doctor, walk-in clinic, or emergency department), address mental health stigma, promote preventive care and vaccination, and share timely updates on local community health programs.

- **Administrative Support:** Offer help with healthcare-related form completion and paperwork.
- **Interpreter Services:** Enable healthcare providers to arrange for community peer support who can communicate with patients from diverse linguistic backgrounds.

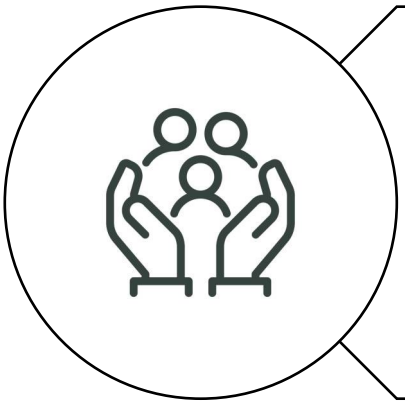
2. Organizational Level

- Improved **Primary care acces**s: Afterhours clinic & Urgent care clinic
- Onsite **childcare** and flexible scheduling for caregivers in health programs
- Embedded **financial case workers** (ODSP/Ontario Works liaison with healthcare helpdesk
- Culturally inclusive **fitness areas**/ (women-only fitness/gym space)
- Training in culturally informed practices, anti-bias **training for healthcare provider**

3. Community- Policy Level

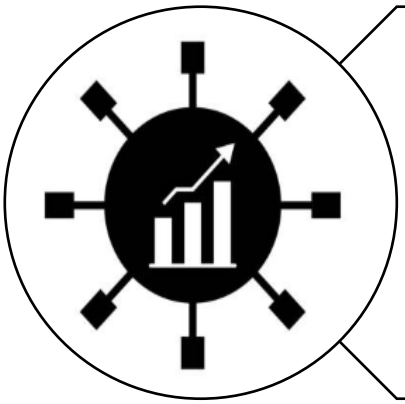
- Subsidized **transportation** (hospital shuttles/transit passes/direct TTC route to hospital)
- Expand **team-based** integrated care models
- Permanent **Urgent Care Clinic** and After hours clinic to improve primary care access

Figure 5. *Community-informed solutions identified in East Toronto's Thorncliffe and Flemingdon communities, mapped using the Social Ecological Model. Strategies reflect an integrated and culturally responsive approach across individual, community, service provider, and policy levels. Adapted from the CDC framework on health promotion.*[48]



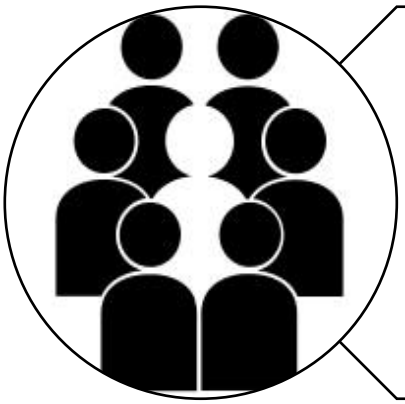
Community and Policy

- Sustained fudning for **Urgent care clinic, Dental clinic**
- Policy support for **expanding team based care**
- **Female doctors** for pregnancy/health issues
- Subsidized Medical **transport/shuttle** and direct hospital transit routes



Organizational level

- Improved **Primary care access**: Afterhours clinic & Urgent care clinic
- **Financial case worker** integrated with healthcare services (OW/ODSP)
- **Childcare support** for healthcare programming
- Gender specific gym, exercise **fitness** programs
- Training in culturally informed practices, antibias **training for healthcare provider**



Interpersonal level/Individual level

- **Multilingual Community Health Help Desk** *(trusted, first point of contact to bridge residents with local healthcare providers)*
  - Health System & referrals/appointments Navigation
  - Digital healthcare tools assistance
  - Administrative /forms support
  - Multilingual, culturally sensitive education
  - Connection to supports available for Mental health, Caregiver and Family Support Needs

CONCLUSION

This study underscores the necessity of a coordinated, culturally responsive, and system-integrated care models tailored to the realities of newcomer women in urban Canada. While formal attachment to primary care remains high, persistent reliance on walk-in clinics and emergency services reflects systemic misalignments between policy goals and lived experience.

The findings point to a constellation of barriers including language, scheduling, transportation, stigma, and lack of navigation support that disproportionately affect racialized, low-income, and immigrant populations. Variability in service prioritization further reveals that standardized approaches to access and equity are insufficient in the absence of cultural and contextual sensitivity.

Implementing the multilevel recommendations grounded in the Social Ecological Model can enable health systems to shift from fragmented, one-size-fits-all interventions to relational and adaptable structures rooted in trust. Emerging initiatives such as the Thorncliffe Community Hub, which offers integrated services including dental and youth care, provide promising examples aligned with Canada's Primary Care Action Plan.5

Ultimately, advancing health equity in line with the Quintuple Aim will require sustained funding, community-led solutions, and a decisive shift from institutional inertia and fragmented programs to a committed focus on transforming broader system and community needs.

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