

Healthcare service needs for refugees, asylum seekers, and residents with precarious immigration status in Canada: A scoping review

Abstract

Context: According to the World Bank (2023), 184 million people, constituting 2.3% of the world's population, migrated globally. Even though over 23% of Canada's population are immigrants (of whom 130,125 were refugees in 2021), recent data on the demographics, vulnerabilities, and healthcare needs of Canadian refugees, refugee claimants, and residents with precarious immigration status in Canada are scant.

Objective: Conduct a scoping review for the last 10 years to understand the trends of influx and vulnerabilities and identify the unique healthcare and well-being needs of these equity-deserving immigrants living in Ontario since it is the destination province for 50% of Canada's immigrants, with Toronto as a primary destination.

Methods: A scoping review study was conducted in 2024 by reviewing peer-reviewed articles from databases and an environmental scan of government reports and documents published in the last 10 years. Structured scoping review principles and the Preferred Reporting Item for Systematic Review and Meta-analysis extension for Scoping Review (PRISMA—ScR) model were used to ensure the robustness of the data. Articles focusing on Canada and countries with comparable economies and immigration laws were reviewed. After charting, the data were thematically analyzed.

Results: The number of refugees in Canada has consistently increased. Findings indicated that this group experienced social disparities, including vulnerable socio-economic status, food insecurity, social exclusion, and resettlement stressors compounded by trust issues, cultural recognition, and linguistic barriers. Studies report a higher prevalence of chronic diseases such as anemia, diabetes, high blood pressure and mental health issues such as mood disorders, anxiety, depression, and PTSD. Findings also suggested that this group experienced substantial barriers to health care, including inadequate cancer screening, suboptimal chronic hepatitis management, and underutilization of psychiatric care, attributed to a lack of awareness about opportunities, cultural stigma, and language challenges.

Conclusion: Study findings underscore the necessity for targeted healthcare services in Canada to meet the identified needs of refugees and residents with precarious status. Policymakers should focus on improving awareness, accessibility, and cultural competency in healthcare provision. More focused and culturally appropriate research is required to identify the unique needs and opportunities to support this equity-deserving population.

Keywords

Immigrants, refugees, refugee claimants, healthcare needs, mental health, and Non-status

Background

The World Bank report in 2023 highlighted that 184 million people, constituting 2.3% of the world's population, are displaced from their land of birth (World Bank Group, 2023). Canada is a welcoming host country accepting migrants, including refugees and immigrants. Each year, approximately 250,000 people immigrate to Canada, contributing to about two-thirds of the country's annual population growth (Lum et al., 2016). Statistics Canada (2023) reports that 23% of Canadians are immigrants, including refugees, asylum seekers, and residents of other precarious immigration categories. These numbers for immigrants are constantly increasing, yet their access to health services is inconsistent with the Canadian-born population (Gushulak et al., 2010).

Refugees, refugee claimants, and residents with precarious status are an understudied equity-deserving population (EDP) subgroup in Canada. They face many challenges, including access to financial services in the Global North, which limit their integration and directly affect other social aspects and healthcare access (Zhang, 2023). One study published in 2021 described emerging evidence of the disparity in access to mental health consultations (Zhang, 2021). In 2010, Swinkels et al. identified the gaps in the healthcare needs of this marginalized population, which was then utilized to construct a guideline to deliver tailored care for immigrants (Swinkels et al., 2010; Pottie et al., 2010).

Studies indicated that immigrants face a higher risk of various adverse health outcomes compared to Canadian-born individuals. Research has shown that immigrants are significantly less likely to undergo cancer screenings (Howlett et al., 2009), Pap Tests (Lebrun & Dubay, 2010), and experience poorer postpartum health (Sword et al., 2006; O'Mahony & Donnelly, 2010; Ganaan et al., 2012). Additionally, evidence suggests that immigrants are less likely to be tested for chronic conditions (Woltman & Newbold, 2007), which increases their risk of mortality if diagnosed with such conditions (Pavlish et al., 2010). These poorer health outcomes are often partly attributed to the barriers they face in accessing healthcare (Pavlish et al., 2010).

The physical and mental health outcomes for EDPs can be drastically affected by disruptions to the acculturation process caused by the social determinants of health (SDoH) intersecting with medical complexities, perceived discrimination, stigma, and depressive triggers in the host community. (Naidu et al., 2023; Smith et al., 2021). These disruptions, including racism, interfere with integration, and, as a result, refugees are more likely to be forced into assimilation, separation, or marginalization as a means of coping (Berry & Hou, 2016). Other coping facilitators include self-

efficacy, social capital, cultural relativism in healthcare access and delivery, social support systems, and healthy public policies. The colonial infrastructure makes This population vulnerable, causing them to integrate into the mainstream labour market with productivity that affects their health outcomes. A 2019 published report by the Public Health Agency in Canada recognized stigma as one of the drivers of health inequity and suggested public health initiatives toward a more inclusive healthcare system (Government of Canada, 2021)

Despite the significant influx of immigrants, there is a scarcity of recent data addressing the shift in the demographics of refugees, refugee claimants, and residents with precarious status, as well as the evolving healthcare needs of this EDP. Research on the health needs of this underserved population is required. It would help provide a framework to build focused governmental policies and guidelines, ensuring their access to equitable healthcare services. This study identifies this gap by comprehensively analyzing recent and relevant literature. It summarizes the results of a rigorous scoping review. It serves as a situational analysis to outline the problems, barriers, and recommendations for developing a refugee-friendly healthcare system at the micro, mezzo, and system levels.

Aim and objectives

Research addressing incoming trends, vulnerabilities, and health service needs of refugees and other EDPs in Canada is poorly financed. Given the need to capture the gravity of this problem, a targeted review helps to clarify research priorities, identify gaps and generate evidence that can be utilized to improve their integration, health, and social well-being. The primary objective of this study is to portray the trends of the influx of refugees, refugee claimants, and residents with precarious status and identify their healthcare needs. Specifically, the study aims to answer the following research questions:

- 1) What has Canada's immigrant population trend been over the last 10 years?
- 2) What are their healthcare and well-being needs and challenges?
- 3) What can be done at different levels to integrate refugees and other EDPs with dignity?

Methodology

This was a descriptive qualitative study for searching relevant literature, reports, registers, and other grey documents in the government and non-governmental sectors to understand the scope of further study (Sandelowski, 2000; Daly et al., 2007). The literature review and environmental scan (Nagi et al., 2020) in this study followed Arksey and O'Malley's (2005) five-stage model of Scoping Review with some modifications by Alamgir et al. (2022) by incorporating, as collaterals, other rigorous tools like Preferred Reporting Item for Systematic Review and Meta-analysis extension for Scoping Review (PRISMA- ScR) procedure to ensure the robustness of data sorting and analysis.

Stage 1: Identifying the research question

A co-design approach was used to identify the research question and capture the most expansive search results. The research question was framed with the support and consultation of the librarian at the Gerstein Library of the University of Toronto. The definitions were used as per the Immigration, Refugees and Citizenship Canada (IRCC) reports (2023) and the WorldBank (2023). The research questions were collaboratively rephrased and redefined to ensure that they were specific and broad enough to serve the study's objective.

Stage 2: Identifying relevant studies

The literature was derived from Ovid Medline, Embase, PsychInfo, and EBSCO databases and from a search for open-access articles. The librarian at the Gerstein Library was also consulted while building the structured search string, which was developed using Medical Subject Headings (MeSH) and text-word search strategies to obtain the most comprehensive results by achieving greater recall and precision (Demars, 2022). These concepts were used for concept mapping (Immigrant – Refugees - Healthcare services – Mental Health – Social well-being – Emotional health) and were included in the search string.

Stage 3: Study selection

The original search (N=1,093) was guided by filtering out articles published before 2013 to reflect the recency of immigration practices and patterns. Articles published in English or have available English translations were selected. To study comparable immigration protection and support behaviour, we aimed to involve studies conducted in North America, European countries, Australia, New Zealand, Japan, and South Africa. The articles retrieved by inclusive sorting of Canadian literature were utilized to get more focused data regarding the trends and the identified health needs in the Canadian context. The articles would be eligible for inclusion if they were full text, accessible from the last 10 years, and focused on the defined target population in Canada. On the other hand, international studies from countries of comparable economies and similar immigration policies were used to match the data for each targeted area of research within an international context. In this global arm, full-text articles with a high level of evidence were eligible for inclusion if the studies were conducted in countries comparable to the Canadian context. Studies were considered irrelevant if they had variations in definitions of foreign residents, focusing on internal migration, including immigrants kept in detention or second-generation immigrants.

Stage 4: Data charting

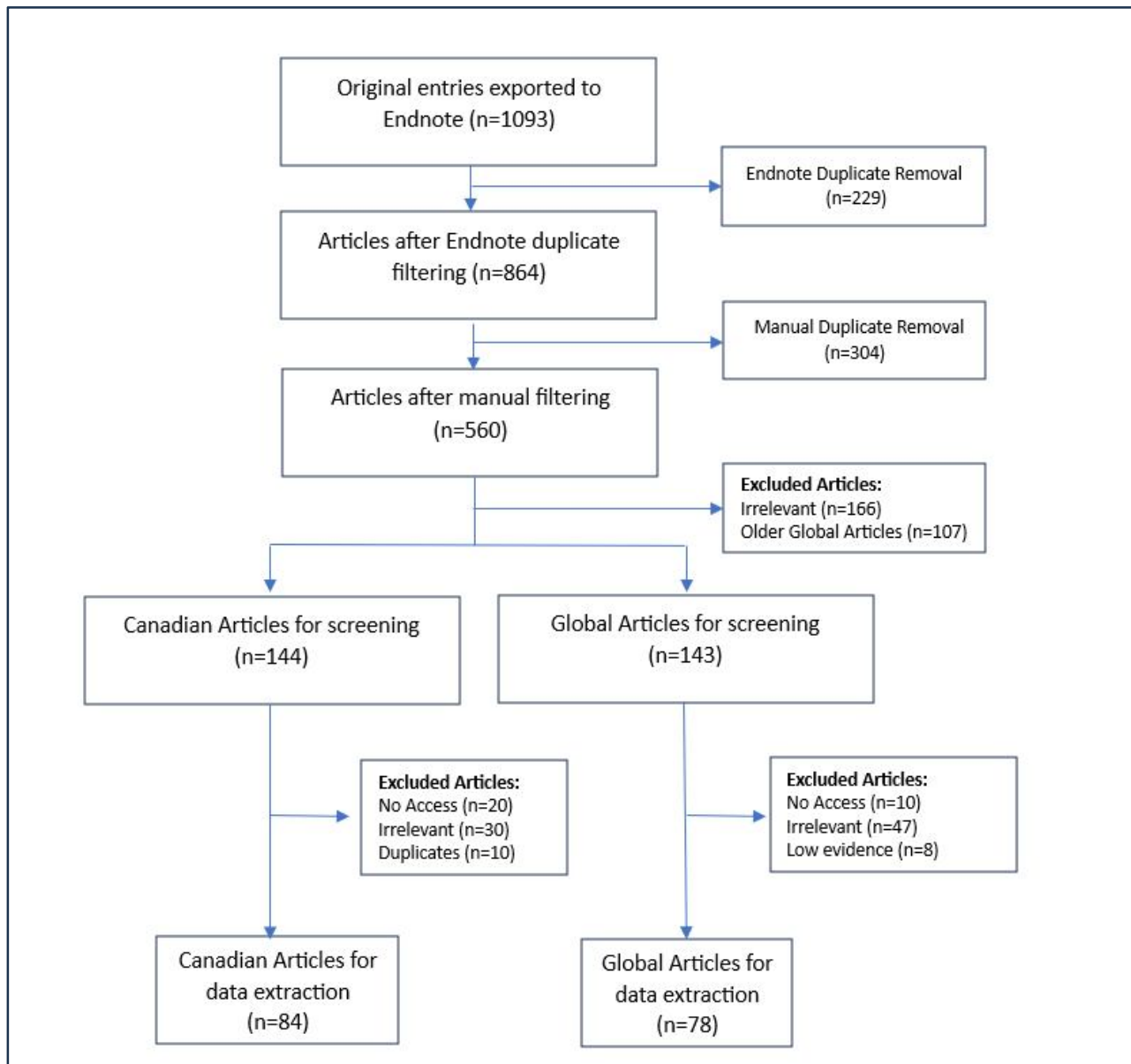
The original entries were exported to Endnote Library, and duplicates were removed. The selected articles (n=560) were exported and managed into the Endnote Library (**Figure 1**). They were first screened at the title/abstract stage to ensure the inclusion and exclusion criteria were met. The filtered articles were evaluated based on the Critical Appraisal Skills Programme (CASP checklist, 2020) and presented using the PRISMA-ScR (Tricco et al., 2018) model. Data from these full-text articles were extracted and organized using a tailored charting tool that was agreed on by the team members. The headings included: author, geography, publication date, title, DOI number, source, reason of direct exclusion, study design, level of evidence, purpose, sampling method, data collection method, data analysis, overarching themes (population subtype/unmet service need/trends), coded themes (health/mental/social wellbeing/others), key findings, strengths, limitations, quality appraisal score.

Stage 5: Collating, summarizing and reporting results

The two field researchers (MY and SP) independently analyzed the thematic analysis of data that was strategized following Braun and Clarke's approach (Braun et al., 2012) with repeated engagement of the principal investigator (AA) to resolve any differences of opinion and finalize the codes to themes.

Considering the differences in perspectives, the data analysis was conducted initially in two arms: (A) Canadian literature and (B) Global literature. The results from both arms were compared and matched for similarities and differences. After accounting for repetency, duplicity, and time constraints, 560 articles were thoroughly screened out of 1,093 articles from Ovid Medline, Embase, PsychInfo, and CINAHL (EBSCO) (**Figure 1**).

Figure 1: Flow Diagram of Study Selection (PRISMA-ScR framework)



After reviewing the data, a report including a summary of the data was visualized to represent the trends of the EDPs in Canada and their distribution according to different geographical areas in the last 10 years. The global refugee influx was also depicted per country of settlement. A thematic analysis was used to report the health complexities and identify service needs. There were three coded categories used for the articles: [1] health service needs, [2] mental health service needs, [3] social well-being, emotional health and scales of disparity. The overarching themes within each coded category were listed and mapped across different sections in Ontario, Canada and globally.

Stage6: Consultation exercise

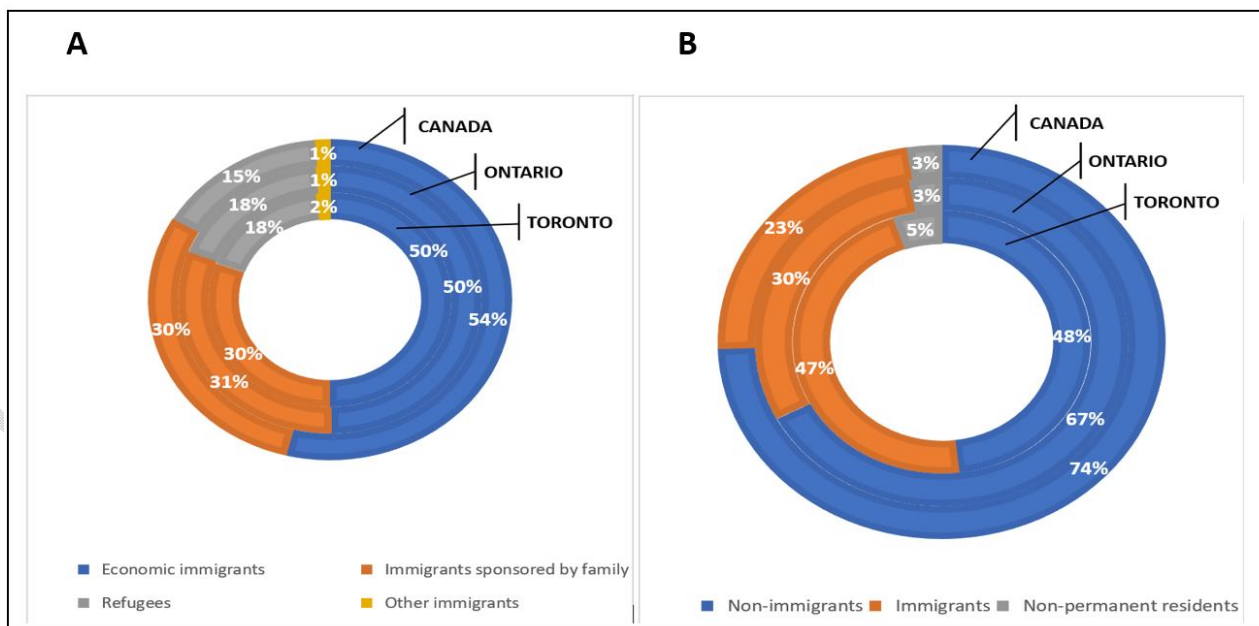
According to Arksey and O’Malley (2005), even though this step was optional, it was practiced repeatedly throughout the process, as discussed at each stage. With their expertise, the team met repeatedly and reviewed all study elements, from the study protocol to every step of the process. The librarian’s support at Gerstein Library at the University of Toronto was pivotal in the first stages. The trained researchers conducted the research collaboratively and consulted repeatedly with the lead researcher and other expert internal stakeholders from Access Alliance MHCS.

Results

The influx of refugees, refugee claimants, and residents with precarious immigration status

Ontario hosts 50% of the overall immigrants arriving in Canada, with 30% of them concentrating in Toronto (Statistics Canada, 2023). Almost half of the population of Toronto are immigrants, and 5.3% of residents have a precarious status (Figure 2A). There are nearly 187,000 refugees in Toronto, constituting 32% of those in Ontario and 18% of Canada’s total refugees since 1980. Ontario hosts around 56% of the total refugees who were admitted, while 2% of Toronto’s population are classified as “other immigrants” (These are residents with precarious status as defined by this article) (Figure 2B).

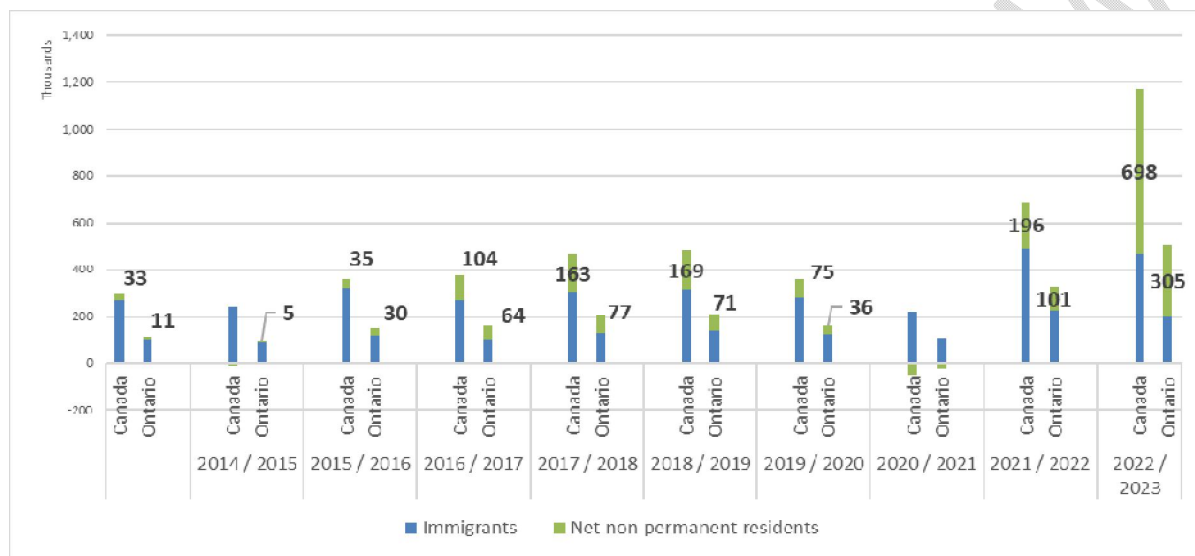
Figure 2 Population distribution across Canada, Ontario, and Toronto (Census, 2021)



Source: Statistics Canada. 2023. Census Profile. 2021 Census.

Trends in immigrant growth increased significantly across Canada between 2011 and 2021. Thirty percent of the immigrants arrived between 2011 and 2021, with persistent growth in the last 5 years (18, 27, and 37% in Canada, Ontario, and Toronto respectively)(Statistics Canada, 2023). In 2022/2023, the number of non-permanent residents quadrupled in Canada (approximately 700 thousand) and tripled in Ontario (305 thousand) (**Figure 3**).

Figure 3: Annual estimates of the components of international migration in Canada and Ontario for the last 10 years.

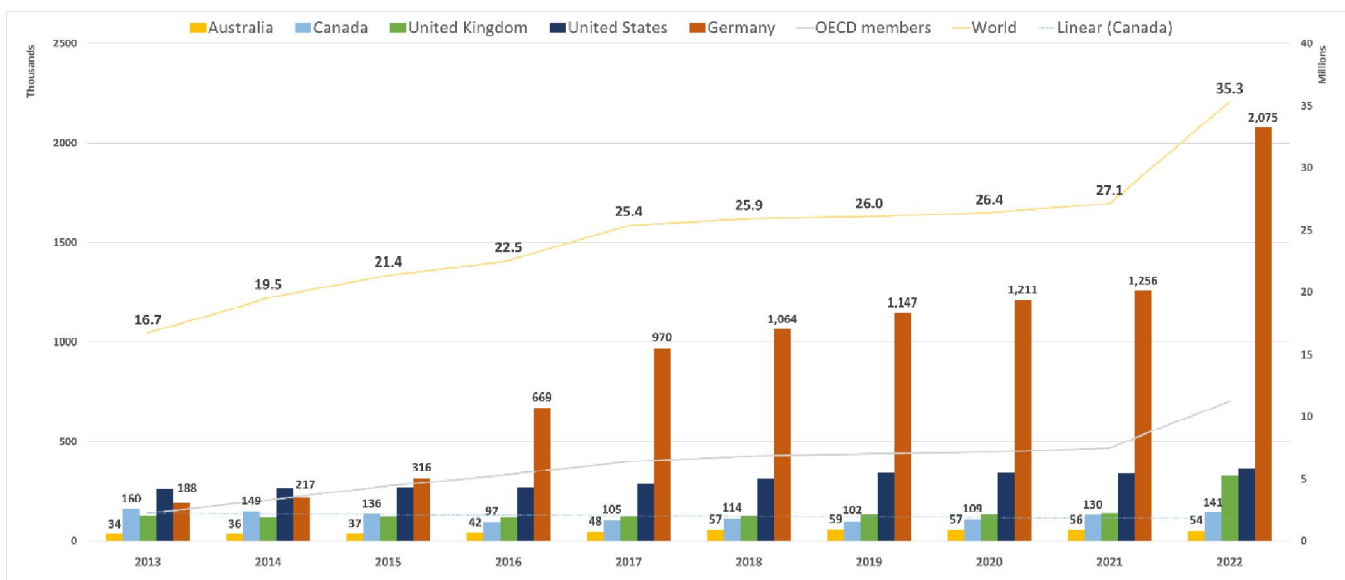


Source: Statistics Canada 2023.

Data from IRCC showed that the influx of refugees has been consistently increasing since 2013, and the “other immigrants” category has doubled in 2021 (3% of the population). In the last nine years, 42% of the resettled refugees were located in Ontario with almost half of them being government-assisted (Statistics Canada, 2023). There was a continuous increase in non-permanent residents who are work or study permit holders and their families (unless families have PR or citizenship) or temporary resident permits (formerly known as “Minister’s Permits”)(Statistics Canada, 2023). Asylum Claimants were less than 20,000 in Canada (66% residing in Ontario) in 2014. After 10 years, the numbers grew tenfold in Canada, with 44% of them residing in Ontario(IRCC, 2022).

Globally, refugee numbers are constantly increasing in countries that are members of the Organization for Economic Co-operation and Development (OECD) (World Bank, 2024). The US has received more than 300,000 refugees per year in the last five years, whereas the UK witnessed a double number in 2022. Canada has maintained the number of refugees to 100-150 thousand annually, constituting 2% of the OECD countries’ total and 10% of the World’s total in the last decade(**Figure 4**).

Figure 4 Trends of global refugee numbers per country of settlement in the last 10 years.



Source: World Bank 2024. World Development Indicators

Health Complexities and identified service needs

A. Thematic Analysis of Canadian Literature

The first group of reviews included 144 Canadian articles. Of these, 60 articles were excluded. Eighty-four articles were screened, and data was extracted (n=84). Most of the articles were at a national level (42%) or from Ontario (40%), with only 6% of articles being specific to Toronto. These articles covered themes related to the lack of patient-centred care, barriers to accessing breast cancer screening and perceived discrimination against homeless immigrants and its effect on mental health. Nine articles focused on refugees (Barry, 2020; Beiser, 2016; Darwish, 2020; Farid, 2020; Gruner, 2022; Hansen, 2016; Lim, 2016; Redditt, 2015; Sim, 2023) and 8 articles targeted either refugees & asylum seekers or refugees and recent immigrants (Edwards, 2022; El-Bialy, 2015; Gagnon, 2014; McKnight, 2020; Saunders, 2018; Sayed, 2023; Torres, 2013; Woodgate, 2018). Only one article focused on the medically uninsured (Bunn, 2013). One-third of the articles discussed “identified health service needs,” compiled in **Figure 5**. One particular study outlined the needs in the Toronto area, highlighting the higher prevalence rates of chronic diseases such as anemia, elevated blood pressure, and impaired glycemic control among refugee patients compared to the general Canadian population. Moreover, it linked potential underdiagnosis and undertreatment of chronic diseases among refugee populations to limited access to healthcare services, cultural barriers, and lack of awareness (Redditt, 2015). More than half of the articles detailing the identified health service needs originated from Ontario, which made the list relevant

to our research. In total, 24 articles discussed identified mental health service needs, which are tabulated in **Figure 6**. Half of these articles originated from Ontario. Thirty-seven percent of the articles covered social and emotional well-being and issues of disparities related to these groups. Two articles mentioned environmental exposures and discussed the risk of deterioration of health (Kirby-McGregor, 2023; Sundaram, 2021). Bunn et al. (2013) listed the reasons for patients lacking health insurance, such as the landed immigrant health insurance waiting period, lack of permanent resident status, lost or expired health insurance cards, and foreign visitor status, which indicates barriers to accessing healthcare services. It also highlighted that this population had a higher prevalence of HIV (Bunn, 2013).

B. Thematic Analysis of Global Literature

The second group of articles included 143 articles originating globally from countries of comparable economies and similar immigration policies, of which 65 articles were excluded to extract data from 78 articles. The articles were mostly generated from Europe since it has welcomed most of the global refugees in the last 5 years. Also, more than 20 articles were from Australia, which largely resembles the geographical, economic, and immigration policies of Canada (Jiang, 2023; Blackmore, 2022; Doma, 2022; Nickerson, 2022; Adhikari, 2022; Gallegos, 2021; Hawkes, 2021; Nickerson, 2021; O'Donoghue, 2021; Roder, 2021; Rogers, 2021; Guo, 2020; Kayrouz, 2020; Stuart, 2020; Ziersch, 2020; Baker, 2019; Bryant, 2019; Chen, 2019; Nickerson, 2019; Slewa-Younan, 2019). Australia's important national longitudinal study was the "Beginning a New Life in Australia" (BNLA). The data registry from this national registry generated tens of consequent studies demonstrating correlation or long-term monitoring of the immigrant's health status or needs (Department of Social Services, 2017).

Most of the included studies addressed mental health service needs, including post-traumatic stress disorder (PTSD), Anxiety, and others, summarized in **Figure 6**. The highest occurrence in identified health service needs globally was underdiagnosis or mismanagement of chronic conditions listed in **Figure 5**. The list of identified service needs per category was tabulated and matched with the Canadian literature in **Figures 5,6,7**. Other health service themes occurring globally were perinatal care, cardio-metabolic disorders and risk factors, skin problems, vision and hearing impairment, various infectious diseases and antibiotic resistance, heart failure-related hospitalizations and all-cause mortality, asthma, reproductive health and gynecologic health problems, endocrine diseases, obesity, higher fracture risks, high prevalence of sexually transmitted infections (STIs) and HIV with limited awareness, high rates of under-5 mortality, adverse childhood experiences with growth and development issues and food insecurity.

Throughout the analysis of the articles included in this scoping review, several problems were identified at the individual (micro), community (Mezzo), and system (macro) levels. These

problems included healthcare access and insurance at the micro level, in addition to chronic diseases and cancer screening at the community level. The problems at the system level were settlement and mental health issues. The barriers for individuals included cultural shock and stigma, language challenges, and perceived discrimination. They also extended to food insecurity and vulnerability to socioeconomic status (SES), whereas the system barriers included resettlement stressors, cultural recognition, trust issues, and language barriers(**Figure 8**).

Figure 5: List of identified health service needs in Ontario, Canada and globally.

IDENTIFIED HEALTH SERVICE NEED	ONTARIO	CANADA	GLOBAL
Diabetes OR Impaired Glycemic control	<input type="checkbox"/>		<input type="checkbox"/>
Anemia	<input type="checkbox"/>		
G6PD Deficiency	<input type="checkbox"/>		
Tobacco Use	<input type="checkbox"/>		
Elevated Blood Pressure OR Hypertension	<input type="checkbox"/>		<input type="checkbox"/>
Limited access to quality care in critical illness	<input type="checkbox"/>		
Sub-optimal Chronic Hepatitis diagnosis and management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cirrhosis	<input type="checkbox"/>		<input type="checkbox"/>
Discrimination in prenatal care (especially based on HIV status)	<input type="checkbox"/>		
Lower use of Cardioprotective and Essential medications	<input type="checkbox"/>		<input type="checkbox"/>
Limited access to healthcare services &and limited health checkups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke Care & Outcome	<input type="checkbox"/>	<input type="checkbox"/>	
Inadequate Cancer Screening and receiving Chemotherapy (Cervical- Breast - Lung - ALL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Catch-up immunization & Vaccine Hesitancy		<input type="checkbox"/>	<input type="checkbox"/>
Acute Upper Respiratory disorders		<input type="checkbox"/>	<input type="checkbox"/>
Dental Care		<input type="checkbox"/>	<input type="checkbox"/>
Accessing specialized hematological care		<input type="checkbox"/>	
Delay in TB screening or multi-resistant Tuberculosis		<input type="checkbox"/>	<input type="checkbox"/>

HIV: Human Immunodeficiency Virus; ALL: acute Lymphocytic Leukemia; TB: tuberculosis
 (Ahmad F, 2013; Banerjee A.T., 2018; Barry, R.M, 2020; Corsi, D. J., 2016; Dong, K., 2023; Ferdous, M., 2018; Gruner, D., 2022; Gupta, S., 2014; Hansen, L., 2016; Kamstra, R. L., 2016; Leafloor, C. W., 2023; Lim, R., 2016; Lin, Shen, 2022; Lofters, A. K., 2021; Lum, I., 2016; McDonald, J. T., 2017; Ng, R., 2015; Osiowy, C., 2022; Redditt V. J., 2015; Sayed, N., 2023; Shah, B. R., 2014; Siddiqi, A. A., 2016; Sundaram, M. E., 2021; Vahabi, M., 2016; Vyas, M. V., 2020; Vyas, M. V., 2021; Walsh, R. L., 2021)

Figure 6: List of identified mental health service needs in Ontario, Canada and globally.

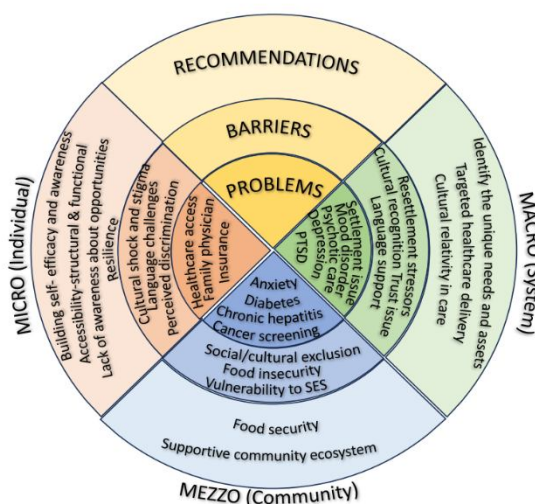
Ontario	Canada	Global
Delayed access to outpatient healthcare services, underutilization of services, or lack of culturally competent mental health service		Under-utilization of Psychiatric care, Outpatient mental health services, drug dependency services & Mental health literacy issues
Mood Disorder		OCD/ Phobia/ Prolonged grief disorder
Anxiety Disorder		Anxiety
Early identification and intervention for postpartum anxiety and Perinatal mental health services		Perinatal mental health screening and Postpartum Depression
Depression screening and mental health care seeking in these populations		Depression
-	Emotional and Conduct disorder in youth	Dementia and standardized care
Poor mental health due to a History of Assault	-	Other mental health issues (Psychological distress, Violence, stress due to language barriers)
-	Poor mental health due to isolation	Correlation of SES, social support, social isolation to mental health
-	Poor mental health due to Trauma	PTSD &Trauma-related Care
Early Psychosis with risk of involuntary hospitalization	-	Psychosis
-	Risk of fall injuries associated with mental disorders	-
-	Schizophrenia spectrum disorders & Suicidal risks	-
Hyperactivity Disorders in children	-	-

OCD: Obsessive Compulsive Disorder; SES: Socioeconomic status; PTSD: Post-traumatic stress disorder
 (Anderson Kelly K, 2015; Barker, L.C, 2023; Chen, Y., 2013; Comeau, J., 2019; Davison, K. M., 2019; Dennis, C. L., 2018; Edwards, J., 2022; Farid, D., 2020; Finnigan, C., 2022; Hettige, N. C., 2017; Islam, F., 2015; Lebenbaum, M., 2021; Maraj, A., 2017; McKnight, A., 2020; Nadeau, L., 2018; Oliffe, J. L., 2021; Phillips S. P., 2021; Rivera J. M. B, 2021; Rodrigues, R., 2019; Saunders, N. R., 2018; Sim, A., 2022; Vahabi, M., 2017; Vigod, S., 2016; Whitley, R., 2017)

Figure 7: Identified needs of Social Wellbeing, Emotional Health and Scales of Disparity in Canada and globally.

	Ontario	Canada	Global
Disparities to access care caused by knowledge or social, cultural, racial, geographical, stigma and language barriers OR limited disease awareness and trust of health care provider	✓	✓	✓
Emotional Problems/ Aggressive Behavior / Mental health due to Discrimination and Social isolation, resettlement stressors and Lack of support for chronic illnesses	✓	✓	✓
Socioeconomic disadvantages affecting health outcomes and potential malnutrition	✓	✓	✓
Family violence		✓	
Unmet needs in parenting support and education		✓	
Lack of health promotion services for HIV		✓	
Cyber-criminalization vulnerability		✓	

Figure 8: Problems, barriers, and recommendations at the micro, mezzo, and system levels



Discussion

The results of this study are essential to understanding the recent trends of the influx of refugees, refugee claimants, and other immigrants with precarious status in Canada. In this paper, we tracked the trends and magnitude of the EDPs and prepared a population health matrix connecting to their vulnerabilities, needs, and well-being status. We identified the documented health, mental, and social service needs in Canadian territories that have been recorded over the last decade. We

matched them with those of countries of comparable economies and immigration policies to shed light on the importance of creating a common canvas for the unique needs of these refugees. Nevertheless, we considered that sometimes these triggers can arise from the country of origin. The article summarized the challenges and factors that have the potential to facilitate the successful integration of this population in Canada.

At least half of the immigrants landing in Canada choose Toronto as their preferred location (Statistics Canada, 2023). Although landed immigrants receive universal health coverage upon arrival, other non-economic immigrants have limited access to various health services and face many social challenges, such as food insecurity, discrimination, and language barriers, among others (Dahal, 2022). In Canada, refugees and the other EDP subgroups burden the province's and city's capacity to provide the required services for these susceptible groups (City of Toronto, 2022). Integration of these groups is the ultimate goal of the migrants and the host community since it affects the whole acculturation process, as depicted in Berry's model (Berry et al., 1989). However, their integration is challenged by barriers at the individual, community, or system level. Moreover, the health service needs of EDPs are often not studied enough and sometimes overlap with those of economic immigrants, which does not properly showcase their unique struggles.

The three most commonly identified health service needs consistently reported in Canada and globally were (i) limited access to health care services" (Ahmad, 2013; Anderson Kelly, 2015; Barker, 2023; Barry, 2020; Bulle, 2023; Bunn, 2013; Dong, 2023; Ferdous, 2018; Haghiri-Vijeh, 2022; Jurcik, 2019; Lin, 2022; Lukman, 2023; Lum, 2016; O'Neill, 2022; Oliffe, 2021; Redditt, 2015; Rivera, 2021; Rodrigues, 2019; Salma, 2018; Saunders, 2018; Shah, 2014; Siddiqi, 2016; Sundaram, 2021; Torres, 2013; Turin, 2021; Vahabi, 2016; Vigod, 2016; Woodgate, 2018; Adhikari, 2023), (ii) inadequate cancer screening and receiving chemotherapy (Ahmad, 2013; Ferdous, 2018; Hulme, 2016; Lofters, 2021; McDonald, 2017; Vahabi, 2016; Walsh, 2021; Roder, 2021; Nagamatsu, 2020), and (iii) sub-optimal chronic hepatitis screening and management (Corsi, 2016; Gruner, 2022; Kamstra, 2016; Osiowy, 2022; Sayed, 2023). Limited access to healthcare services was linked to various barriers including social, cultural, linguistic, geographical, trust issues and stigma (Cauch-Dudek, 2013; Dahal, 2022; Darwish, 2020; Haghiri-Vijeh, 2022; Lukman, 2023; Lum, 2016; Turin, 2021; Woodgate, 2018; Jankowski, 2022; Poppleton, 2022; Adhikari, 2022; Rogers, 2021; Guo, 2020; Nagamatsu, 2020; Jolof, 2024; Na, 2016). Eventually, most of the studies directly attributed these barriers to negative outcomes in this population's health. These barriers are related to the host country, and studies need to focus on investigating their impact and propose strategies to overcome them.

Several articles proposed a modification in the training of healthcare providers to better address the needs of refugees and improve their quality of life (Zghal, 2021; Ayhan Baser, 2022). Inadequate cancer screening has also been consistently documented despite the widely described phenomenon of "the healthy immigrant" (McDonald, 2017). This phenomenon is directly linked to

the screening procedures that economic immigrants undergo, which put them in a healthier state once they arrive at their destination. This finding suggests that refugees and other non-screened subgroups before displacement would usually suffer from the misconception and would miss their opportunity to be properly checked. Finally, the consistent mention of the underdiagnosis of chronic hepatitis was also linked to certain origins, like male refugees from African ethnicities (Osiowy, 2022). This might be associated with pre-migration factors, such as the high prevalence of this condition in their countries of origin or under-resourced healthcare systems where chronic illness might be underdiagnosed. The studies suggested steps to overcome these challenges, including increasing awareness and screening using linguistically and culturally adjusted tools. Other chronic diseases that have been documented in Ontario included cardiometabolic disorders, diabetes and hypertension, blood disorders, strokes, and lower use of associated medications because of cost-related barriers and limited access to healthcare delivery (Banerjee, 2018; Cauch-Dudek, 2013; Sia, 2019; Redditt, 2015; Darwish, 2020; Shah, 2014; Vyas, 2023). These results call for implementing practical screening and early detection processes in high-risk EDPs, improving chronic disease management tailored to their needs, and enhancing funding and collaboration to improve policies that deliver equitable healthcare access.

Mental health service needs were studied as a category on its own because of the high turnout of documentation in the literature. Refugees and other uninsured groups showed a high prevalence of mood disorders, anxiety, depression, prolonged grief disorder, psychosis and PTSD (Anderson Kelly, 2015; Davison, 2019; Dennis, 2018; Edwards, 2022; Farid, 2020; Islam, 2015; Maraj, 2017; Phillips, 2021; Rivera, 2021; Rodrigues, 2019). These subgroups were also linked to under-utilization of offered psychiatric care, outpatient mental health services, drug dependency services as well as mental health literacy issues (Whitley, 2017; Vigod, 2016; Saunders, 2018; Rivera, 2021; Oliffe, 2021; Finnigan, 2022; Farid, 2020; Barker, 2023). They also lacked perinatal mental health screening, and there were reports of postpartum depression (Dennis, 2018; Vigod, 2016; Barker, 2023; Dennis, 2018). In this category, these needs were usually understated among EDPs because they usually show high levels of resilience caused by their displacement and cultural backgrounds, and these conditions require adequate levels of awareness to self-identify and self-report. This remains one of the most challenging services that must be addressed. Focused evidence-based research in this area is required to direct policy initiatives to expand culturally competent services, improve accessibility, integrate mental health into settlement programs, and support community-based interventions leading to long-term care and building resilience. The government can fund longitudinal studies to monitor and track this vulnerable subgroup over time. Moreover, establishing a national database to track all health service needs and utilization, similar to the Australian BNLA study, would strengthen data collection and monitoring of the different subgroups of the immigrant population equally.

The EDP groups also suffer from disparities affecting their social and emotional well-being (SEWB). These groups struggle with socio-economic discrepancies, food insecurity, social isolation and resettlement stressors; which prompts reports of aggression and violence, thus affecting mental health (Barker, 2023; Dahal, 2022; El-Bialy, 2015; Ginn, 2018; Islam, 2018; Jurcik, 2019; Marksteiner, 2019; Sim, 2023; Woodgate, 2018; Zerger, 2014). Moreover, as discussed before, lack of trust, awareness, cultural and belief recognition, and the dominance of linguistic barriers constitute some of the prominently discussed barriers that affect access to provided healthcare services. Understanding and addressing these barriers in a tailored solution would effectively improve the quality of provided services, guaranteeing that they are delivered to these vulnerable groups. Additional research and data collection would provide a strong foundation for establishing culturally competent care. Moreover, partnering with grassroots organizations would foster community engagement, involve them in decision-making, and ensure culturally relevant policy reforms.

Finally, the problems, barriers, and recommendations were compiled from the articles and categorized at the micro, mezzo, and system levels. The challenges listed aligned with previous literature reporting that Canadian refugees struggle with accessing health care and housing, difficulty with the languages, as well as trauma-related mental health issues (Beiser, 2009). In fact, these language barriers complicate the communication between refugees and healthcare providers, which affects the disease management plans and broadens the gap in awareness and access to preventive healthcare (Hadgkiss, 2014; Pottie, 2010). Moreover, although several programs provide financial support, like the Resettlement Assistance Program by the IRCC, it seems that this approach is still insufficient as it does not eliminate the other challenges that affect the integration of this population beyond the financial needs. In addition to such economic programs, it is crucial to dedicate programs for building self-efficacy and awareness and promoting awareness about opportunities and services that offer structural and functional accessibility. At the mezzo level, the synopsis focuses on chronic diseases among EDPs, which intersects with other challenges, including gaps in continuity of care (Siddiqi, 2021), overburdened community healthcare systems (Gushulak, 2019), and stigma around chronic illnesses (Edge, 2013). At the system level, the barriers included resettlement stressors and cultural and trust issues. In addition, other reports have pointed out challenges like lengthy asylum processes, inconsistent provincial policies on healthcare and social services, and systemic discrimination (Hyndman, 2016). These challenges arise from the assimilation of the complex experiences of EDPs in relation to the communities they belong to while interacting with the system and its policies. Future research is endorsed to ensure updated challenges and barriers recognition and to provide the framework to identify immediate and sustainable solutions.

Strengths and Limitations

The study coherently developed the search strategy (keywords, search strings, Boolean operators, wild cards, etc.) with the university librarian, the lead researcher, and the field researchers, who were meaningfully engaged throughout the review process. The study used a librarian-guided process to capture all relevant literature from the databases. The search string was developed meticulously to ensure that all possible and expected keywords were included. However, there were some limitations to the study. A broad and inconsistent definition of immigrants, refugees, and asylum seekers was detected in the global literature and within Canadian governmental references. This caused the inclusion of many articles irrelevant to this research's scope, which was one of the major limitations in extracting and analyzing the data. For example, three articles defined immigrants as humanitarian immigrants, which in Canada undergo a different category (Jiang, 2023; Doma, 2022; Chen, 2019). The study team utilized standard Canadian definitions to overcome the issue. A plethora of diverse literature on this topic was challenging to stay within this study's time frame and scope. The PI's expertise and the librarian's wisdom helped the study team adhere to the research design and scope by concentrating on four databases. Finally, there was an inconsistency in the data availability after the 2021 census, which led to difficulty in mapping the shift in the immigration status of the subtypes.

Conclusion

Refugees and other EDP settle in a new home to integrate with dignity. Even though Canada is renowned for its multifaceted approach to refugee resettlement, there remains an equity gap in the provinces regarding sustainable funding. This study consulted available literature on the trends of refugees, refugee claimants, and residents with precarious status, providing valuable insights into their health needs and service gaps in Toronto. The healthcare challenges faced by refugees and EDPs include limited access to healthcare services, inadequate cancer screening, suboptimal chronic hepatitis management, and a higher prevalence of chronic diseases and mental health issues. Additional barriers, such as lack of awareness about opportunities, cultural stigma, language challenges, social vulnerability, food insecurity, social exclusion, and resettlement stressors, compounded by trust issues and cultural recognition of identities, were also identified. The results commend a strong need for building self-efficacy for resilience, a supportive social support ecosystem, and healthy public policies with culturally appropriate healthcare delivery.

The study recommendations are grouped into individual, community, and system-level implications. The individual-level (micro) actions include raising their awareness of knowledge and utilization of available healthcare services, thus building their self-efficacy, enhancing their structural and functional ability to avail of those services, and feeling included. The community

(mezzo) level action items support them with inclusivity and respect by creating service awareness toolkits in a culturally appropriate design for essential elements like healthcare services, food security, and social support systems. The broader system (macro) can build health promotion-based public policy to create an ecosystem of trust, respect and recognition of their identity. The government, NGOs, and communities should collaborate to conceive sustainable solutions and culturally relevant policies that ensure EDP's advocacy. More research is needed to understand the changing needs of these populations, which can differ depending on where they come from and their situations. Future research should include long-term studies to track health outcomes, develop specific health interventions, and evaluate current programs to ensure they meet the needs of these vulnerable groups conducive to policy advocacy at different stakeholder levels.

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