

Equity, Diversity and Inclusion in Obstetrics and Gynaecology

Prepared by Zainab Doleeb, Maclite Tesfaye, and Dr. Cynthia Maxwell

This primer is not comprehensive. The goal is not to address all equity topics, but rather to inform the reader of their existence in hopes of further engagement with this material outside of this primer. It is also important to be proactive about learning more about the community your hospital or teaching site is serving. When approaching a new site, inquire about the demographics of the patient population, their histories, culture, resilience, and if there are marginalized communities there. Readers are strongly encouraged to practice self-reflection and continual (un)learning beyond this primer and throughout their medical careers.

To discuss, disclose or report mistreatment, including discrimination towards you as a learner or witnessed discrimination towards a patient, you can contact the Learner Experience Office. More information about supports and resources available, including how to book a confidential meeting and protections against retaliation, can be found here: [PGME Learner Mistreatment Resource](#).

Confidentiality

- All patients are entitled to receiving confidential care.
- You may encounter the following scenarios:
 - A pregnant patient in the labour and delivery triage area with a new partner who may not know about their previous medical history (e.g. past therapeutic abortion, past STI, genetic condition).
 - A teenage patient attending prenatal appointments while hiding the pregnancy from their parents.
 - A pregnant patient withholding information from the partner that the fetus has a genetic abnormality.
 - A patient who tests positive for a reportable STI and is anxious about public health contacting their previous partners.
- In such situations, it is prudent to err on the side of confidentiality. Aim to take a history in a private and confidential area. If you are ever in doubt, seek advice from other members of the care team.

Trauma-Informed Care

Incorporating trauma-informed care principles is important in medicine, but particularly in obstetrics and gynaecology due to the sensitive nature of many exams and procedures. Physicians are often unaware of the trauma histories of patients which is why trauma-informed principles should be universally applied to all encounters.¹

Tips

- Clinical Encounters:
 - Review any documentation of trauma prior to patient encounter and avoid asking the patient to repeat traumatic history if unnecessary.

- Signpost – warn and explain the rationale for sensitive questions.
- Notify referrals in advance regarding relevant trauma history so they are appropriately prepared.
- For physical examination and invasive procedures:
 - Ask the patient about anxiety about any parts of the appointment or physical examination and if there’s anything you can do to help make it more comfortable.^{1,2}
 - Offer the patient the ability to stop or pause the exam or procedure at any point should they need a break prior to beginning.¹
 - Determine whether alternate measures are available for examination (e.g. self swab for GBS).¹
 - Describe for the patient what they can anticipate sensing (e.g. you will hear clicking when the speculum opens, you will feel my glove).¹

Resources

- [ICE2 Pelvic Exam and TTC Slides](#)
- [Providing Trauma-Informed Care](#)

Indigenous Patients

Terminology, Epidemiology and Background

- “Indigenous” is a term used to describe all First Nations, Métis, and Inuit people.³
- Métis describes a specific cultural and collective group resulting from the union of Indigenous and European people in Canada.³
- Inuit refers to a distinct group of Indigenous people historically located in the Arctic.³
- First Nations may refer to reserve-based communities, though not all. In a Canadian legal context, it also applies to those who have “status” or are recognized under the Indian Act.³
- Estimated 1.8 million Indigenous people in Canada.⁴

Social Context

- There is a long history of racist and genocidal treatment towards Indigenous people in Canada. Forced removal of land, assimilationist policies, child apprehensions, residential schools, and coerced sterilizations are a few examples.⁵
- This has led to considerable intergenerational trauma which can manifest through poorer health outcomes and a higher burden of disease and mental illness.⁵
- Gynaecological inequities
 - In some regions, Indigenous people experience higher rates of HPV and HIV.^{6,7,8}
- Obstetrical inequities
 - Indigenous pregnant people, in comparison to the general population, have a two times higher risk of maternal mortality.⁹
 - There are higher rates of adverse outcomes: stillbirth, perinatal death, low birth weight, prematurity, and infant death.^{8,10,11}
- Birth alerts remain in practice in many provinces and disproportionately affect Indigenous parents. A birth alert is when a member of the healthcare team flags an expectant pregnant person as “high risk”

for being unable to care for their newborn. After birth, the infant may be apprehended without consent. This policy has been banned in British Columbia, Alberta, Ontario, Manitoba, the Yukon, and PEI, but still remains in practice in Newfoundland and Labrador, Nova Scotia, New Brunswick, Saskatchewan, and Quebec.¹²

Tips

- Recognize the intergenerational impact of colonial policies, residential schools, systemic racism, and their implications on current health and social inequities.
- Acknowledge and respect the role of traditional health practices.
- Indigenous people are diverse. Do not make generalizations or assumptions. Ask patients broad and open-ended questions:
 - “Is there anything we can do to better support you?”
 - “Are there any practices from your culture or background that will help with your healing right now?”¹³

Resources

- [UBC: Indigenous Peoples Language Guidelines](#)
- [First Nations Health Authority: Maternal, Child and Family Health Case Study](#)
- [SOGC Clinical Practice Guideline and Policy Statements: Indigenous Women’s Health](#)
- [National Collaborating Centre for Indigenous Health](#)
- [Indigenous Services Canada](#)

Black-Canadian Patients

Terminology, Epidemiology and Background

- Self-identification as “Black” denotes an individual’s race, not their ethnicity. Individuals who identify as Black may identify as African, Afro-Caribbean, Afro-Latino, African-Canadian or multi-racial.
- In 2016, 7.5% of the Toronto population identified as Black.¹⁴

Social Context

- 15% of Black-Canadian women report their health to be “fair or poor” compared to 11.3% of White-Canadian women.¹⁵
- There is limited data in Canadian journals on racial discrepancies in reproductive health outcomes for Black people.
- American and Canadian research indicates many inequities:
 - Gynaecological inequities
 - African-American patients are less likely to be diagnosed with endometriosis when reporting pelvic pain.¹⁶
 - African-American patients are more likely to be diagnosed with later-stage cervical cancer and have lower survival rates.¹⁷
 - Obstetrical inequities

- In comparison to White infants, African-American infants had higher rates of preterm delivery, low birth weight, and higher infant mortality rates within their first year of life.^{18,19}
 - There are higher rates of preterm birth for Black-Canadians.²⁰
- Racism at the individual, institutional, and cultural level has been well-documented as a contributing factor towards adverse health outcomes.¹⁵⁻²²

Tips

- If a patient or patient's family discloses experiences of racism or discrimination, empathetically listen and validate.
- If a patient would like to report a racist incident, provide resources on your respective healthcare center's patient experience office or the Ontario Patient Ombudsman.
- Reach out to your own colleagues and mentors for guidance and debriefing.
- The Black community is very diverse and includes individuals from across the globe. Patients may have different perspectives on culturally safe care. Avoid making generalizations.

Resources

- [UofT OBGYN Resources: Black Health](#)
- [Mommy Monitor - Experiences of mistreatment of Black women during childbirth](#)
- WombCare provides information and community programs for women of colour with common gynaecological issues: wombcare.ca
- [Black Health Alliance - Knowledge/Research Hub](#)

2SLGBTQ+ Patients

Terminology, Epidemiology and Background

- In 2018, approximately one million people in Canada identified as lesbian, gay, bisexual, transgender, queer or Two-Spirit, comprising 4% of the total population aged 15 and older.²³
- **Gender identity:** each person's internal sense of gender. This can include identifying as a man, woman, both, neither or anywhere along the gender spectrum. A person's gender identity is not outwardly visible to others and may be congruent or incongruent with their sex assigned at birth.²⁴
- **Gender expression:** how a person outwardly expresses their gender. This can include behaviour, clothes, hair, make-up, voice or other perceivable characteristics. Pronouns and chosen names are also a means of gender expression.²⁴
- **Sex:** the anatomical and physiological classification of people at birth. Typically individuals are assigned as male, female or intersex.²⁴
- **Trans or transgender:** describes individuals whose gender identity differs from the sex assigned at birth. "It includes, but is not limited to people who identify as transgender, trans woman (male-to-female MTF), trans man (female-to-male FTM), transsexual, cross-dressers, gender non-conforming, gender variant or gender queer."²⁴
- **Sexuality or sexual orientation:** denotes who a person is or is not physically, romantically or emotionally attracted to.²⁴

- A non-comprehensive list of pronouns you may encounter:
 - She, her, hers
 - He, him, his
 - They, them, theirs
 - Ze, zir, zirs

Social Context

- 2SLGBTQ+ patients experience higher rates of mental illness, chronic disease, infectious diseases, and intimate partner violence. This is related to lack of access to appropriate healthcare, exacerbated by stigma and traumatic medical encounters which further exacerbates medical mistrust.²⁵
- In 2015, approximately 50% of transgender Ontarians with a regular GP reported feeling uncomfortable discussing transgender health issues with their physician.²⁶
- An estimated 21% of transgender Ontarians avoided seeking health services from an ED due to fear of discrimination.²⁷

Tips

- Introduce yourself with your own pronouns. Ask what pronouns a person uses and do not make assumptions.
- If you misgender a patient, apologize and correct yourself.
- Pay attention to the language a patient uses and try to use their terminology when appropriate.
- Use gender-neutral terminology: partner, significant other, pregnant person, chestfeeding, bottom surgery, top surgery.
- Do not make assumptions in regards to care. Transgender men or non-binary individuals with cervixes still require cervical cancer screening. Individuals with a uterus may still become pregnant.
- If a patient discloses experiences of mistreatment, validate their experience and connect with suitable resources.

Resources

- [University of Toronto Primer on LGBTTQQIPS2SAA Health](#)
- [SOGC - Resource Library: LGBTTQ+](#)
- [Gender-affirming Care for Trans, Two-Spirit, and Gender Diverse Patients in BC: A Primary Toolkit](#)
- [Rainbow Health Ontario: Tips for Providing Paps to Trans Men](#)
- [Gender Inclusive Anatomy and Clinical Terminology](#)
- [ACOG - Clinical Guidelines for Lesbian and Bisexual Women](#)

Immigrant and Refugee Patients

Refugee Health Insurance Coverage

- The Interim Federal Health Program (IFHP) provides temporary health coverage for refugee claimants, resettled refugees, protected persons, and victims of human trafficking.²⁸
- IFHP covers outpatient and inpatient services, obstetrical care, diagnostic investigations, prescription medications, and emergency dental care.²⁸

Social Context

- Refugees and other Canadian immigrants experience challenges to accessing healthcare due to language barriers, lack of health literacy, and limited knowledge of the Canadian healthcare system.²⁸
- Refugee status is associated with higher rates of adverse perinatal outcomes such as preterm birth and unplanned Cesarean sections.²⁹
- Immigrants and refugees may face additional barriers to contraceptive care access.²⁸ Contraceptives are covered by IFHP. The SOGC also provides funds through the Compassionate Contraceptive Assistance Program.

Tips

- Advocate and use translation services if a patient with limited English appears to have a hard time understanding. If the hospital does not have such services available, then look for a member of the healthcare team who speaks that language. Using family members to translate should be the last option although it is often the default choice.
- Screen for unmet contraceptive needs, provide HPV vaccination for those aged 9-26, and commence cervical cancer screening in those eligible.³⁰

Resources

- [Evidence-based Clinical Guidelines for Immigrants and Refugees](#)
- [Interim Federal Health Program](#)

Pregnancy and Substance Use

Epidemiology and Background

- Prevalence of substance use during pregnancy in Canada: 11% consumed alcohol, 13% smoked, 5% used illicit drugs.³¹

Social Context

- Not only can substance use lead to worse neonatal and maternal outcomes, but it can also hinder prenatal care. Patients with substance use disorders are less likely to seek prenatal care and they have higher rates of infectious diseases such as HIV, hepatitis, and other sexually transmitted infections.³²
- There are treatment centers available (both outpatient and inpatient) where the goal is sobriety. There are other programs that offer a harm-reduction approach.
- Examples of harm-reduction services that may be offered include clean needles and pipes, methadone therapy, and support for patients wishing to reduce the quantity of cigarettes and alcohol consumed per day.^{33,34}

Tips

- Avoid stigmatizing language or attitudes. Stigma from care providers specifically, and society at large, can be a major reason for why patients may not disclose a substance use disorder or seek care.³⁵
- Meet your patient where they are at. Their priority may not be getting addiction treatment but may be finding stable housing.
- Reach out to allied health, especially social workers, to see what resources are available.

Resources

- The [Toronto Center for Substance Use and Pregnancy](#) provides comprehensive addictions services and obstetrical care in one site.
- Mother Craft is a non-profit organization that offers prenatal and early childhood support programming. Through their Breaking the Cycle Pregnancy Outreach Program they can help pregnant mothers seek treatment and prevent relapse: [mothercraft.ca](#)
- Jean Tweed Centre offers both in-patient and out-patient treatment for substance use: [jeantweed.com](#)

Pregnancy and Intimate Partner Violence (IPV)

Epidemiology and Background

- Abuse is defined as acts or threats that can cause physical, sexual or emotional harm. 10.5% of Canadian women report facing abuse and 4.3% describe it as “severe.”³⁶
- Becoming pregnant, being under the age of 20, having a personal history of depression or past smoking or alcohol use all increase risk of IPV.^{36,37}

Social Context

- IPV can hinder prenatal care and increase the likelihood of adverse pregnancy and birth outcomes (e.g. preterm labour, low birth weight). Children are also at a greater risk of experiencing violence in the home later.³⁸
- Pregnancy is a critical point of intervention because many patients regularly seek care from trained providers during prenatal visits and these can serve as an opportunity for detection and intervention.

Tips

- Many patients may not willingly disclose violence due to shame and stigma.³⁹ Preemptively screen and ask, “Do you feel safe at home?” This is also part of the Ontario Perinatal Record.⁴⁰
- Healthcare workers are mandated to report to a Children’s Aid Society if they suspect that a child aged 17 or younger is in need of protection.⁴¹

Resources

- There are validated screening tools such as the [WAST Screen for Intimate Partner Violence \(WAST-SF\)](#)
- Ontario Network of Sexual Assault/Domestic Violence Treatment Centres: [sadvtreatmentcentres.ca](#)
- ShelterSafe to find a shelter or 24-hr emergency line: [sheltersafe.ca](#)
- Assaulted Women’s Helpline: [awhl.org](#)
- [Healthcare for women subjected to intimate partner violence or sexual violence: A clinical handbook](#)

Patients with Obesity

Epidemiology and Background

- Obesity is defined as a BMI of 30 kg/m² or greater.
- Since 1985, rates of obesity have risen three-fold. In 2016, 26.4% of Canadian adults had obesity.⁴²

Social Context

- Obesity during pregnancy carries many neonatal and maternal risks. Patients with obesity may require closer follow-up and specialized care in tertiary centers with the appropriately trained staff.⁴³

- Pregnant patients with obesity report feeling more shamed, judged, and stigmatized by healthcare providers.⁴⁴

Tips

- Never speak disparagingly about a patient's weight, especially in the operating room while they are under anesthesia.
- Be cognizant of your language. Although people around you may use weight-stigmatizing language, strive to avoid this.
 - Instead of "obese patient," opt for more humanizing person-first language such as "person with obesity."
 - Instead of "morbidly obese," specify with neutral language like "patient with a BMI of 40."
 - When referring to tissue, avoid the word "fat" and use "adipose."

Resources

- [SOCG Guideline Pregnancy and Maternal Obesity Part 1: Pre-conception and Prenatal Care](#)
- [SOCG Guideline Pregnancy and Maternal Obesity Part 2: Team Planning for Delivery and Postpartum Care](#)

Patients of Faith

Epidemiology and Background

- In Canada in 2019, 68% of Canadians reported having a religious affiliation. Over half (54%) said their religious or spiritual beliefs were somewhat or very important to their lives.⁴⁵
- The last 2011 census results for the Greater Toronto Area and Hamilton showed that the most common faiths were Christian (61%), Muslim (6%), Hindu (5%), Sikh (4%), Jewish (2%), and Buddhist (2%).⁴⁶

Social Context

- On your rotations, you may observe different rituals and practices.
- Examples may include varying views on family planning methods and genetic screening, a male partner leaving the delivery room while a parturient is giving birth or a female patient declining male learners or staff due to modesty concerns.

Tips

- Not everyone who identifies with a faith will practice it. For this reason, it is best to allow patients to describe their needs rather than assume it for them.
- Ask patients if they have any dietary, religious or cultural considerations they would like the care team to know.

Resources

- As this is not comprehensive, readers are encouraged to seek their own resources and ask colleagues, including nurses, midwives and hospital chaplains for recommended readings.
- The following readings describe general faith principles and may not be applicable to all patients.
- [The Healthcare Provider's Guide to Islamic Religious Practices](#) (pg. 11-14, 17)
- [Jewish Perspectives on Pregnancy and Childbearing](#)

- [Providing Diversity Competent Care to People of the Sikh Faith](#) (pg. 18-21)

Patients with Disabilities

Epidemiology and Background

- A "disability" is a broad term that can encompass physical, mental, and learning impediments. Some disabilities may be visible while others may be invisible.⁴⁷
- In 2017, 24% of Canadian women reported at least one disability. The most common disabilities were pain-related, limited flexibility or mobility, and mental health concerns.⁴⁸
- In 2017, 10.3% of women over the age of 15 had a disability that affected mobility.⁴⁹

Social Context

- Patients or their caregivers may request menstrual suppression using hormonal treatments due to hygiene reasons or anxiety around menses.^{50,51}
- STIs may be underdiagnosed in adolescents with disabilities because care providers assume that the patient is not sexually active.⁵²
- People with disabilities experience higher rates of postpartum depression.⁴⁹
- Pregnant people with a spinal cord injury, paralysis, and spina bifida are at increased risk of preterm labour.⁴⁹
- People with disabilities may have physical barriers to an assessment (e.g. difficulty transferring to exam table, use of wheelchair).

Tips

- Use person- first language such as "person with a disability" instead of "disabled person."⁴⁹
- Do not assume that someone with a disabilities is not sexually active. Take a respectful, private, and confidential sexual history.⁵²
- If a patient needs to be examined but has mobility issues, ask for additional help from the team with transferring.
- If they cannot remain in lithotomy, alternative positions may be used for assessments such as lying on the side or placing knee to chest.⁵³ Ask the patient what position has been helpful in previous exams.
- Do not assume that someone with an intellectual disability is unable to provide consent. When in doubt, assess for capacity which includes the understanding of the information presented and the appreciation of reasonably foreseeable consequences.⁵⁴
- Remember that people with disabilities have a right to access the same care as their able-bodied peers which includes contraception counselling, cervical cancer screening, and other services.

Resources

- [ACOG Guideline Menstrual Manipulation for Adolescents With Physical and Developmental Disabilities](#)
- [SOGC Guideline No. 416: Labour, Delivery, and Postpartum Care for People with Physical Disabilities](#)
- [Presentation on Reproductive and Obstetrical Care for People with Disabilities](#)

If you have any comments or suggestions for this primer, please email zainab.doleeb@mail.utoronto.ca.

REFERENCES

1. Ravi A, Little V. Providing Trauma-Informed Care. *American Family Physician*. 2018;95(10):655-657.
2. Raja, Sheela, et al. "Trauma informed care in medicine." *Family & community health* 38.3 (2015): 216-226.
3. The University of British Columbia, 2021. *Indigenous Peoples: Language Guidelines Version 3.0*. [online] Vancouver, pp.8-10. Available at: http://assets.brand.ubc.ca/downloads/ubc_indigenous_peoples_language_guide.pdf [accessed 15 October 2021].
4. Government of Canada, Statistics Canada. Indigenous Population in Canada - Projections to 2041 [Internet]. Statcan.gc.ca. 2021 [accessed 2021 Oct 28]. Available from: <https://www150.statcan.gc.ca/n1/pub/11-627-m/11-627-m2021066-eng.htm>
5. Allan B, Smylie J. First peoples, second class treatment: the role of racism in the health and well-being of indigenous peoples in Canada, discussion paper. Wellesley Institute; 2015.
6. Public Health Agency of Canada. Chapter 8: HIV/AIDS Epi updates, July 2010 – HIV/AIDS among Aboriginal people in Canada [Internet]. 2011 Feb [accessed 2021 Oct 15]. Available from: <https://www.canada.ca/en/public-health/services/hiv-aids/publications/epi-updates/chapter-8-hiv-aids-among-aboriginal-people-canada.html>
7. Healey SM, Aronson KJ, Mao Y, Schlecht NF, Mery LS, Ferenczy A, et al. Oncogenic human papillomavirus infection and cervical lesions in aboriginal women of Nunavut, Canada. *Sex Transm Dis*. 2001;28(12):694–700.
8. Wenman WM, Joffres MR, Tataryn I V. A prospective cohort study of pregnancy risk factors and birth outcomes in Aboriginal women. *Can Med Assoc J* [Internet]. 2004 Sep 14;171(6):585 LP – 589. Available from: <http://www.cmaj.ca/content/171/6/585.abstract>
9. Kolahdooz F, Launier K, Nader F, Yi KJ, Baker P, Mc Hugh T-L, et al. Canadian indigenous women's perspectives of maternal health and health care services: A systematic review. *Diversity and Equality in Health and Care* [Internet]. 2016 [accessed 2021 Oct 28];13(5):334–48. Available from: <https://diversityhealthcare.imedpub.com/canadian-indigenous-womens-perspectives-ofmaternal-health-and-health-care-services-asystematic-review.pdf>
10. Luo Z-C, Senécal S, Simonet F, Guimond É, Penney C, Wilkins R. Birth outcomes in the Inuit-inhabited areas of Canada. *Can Med Assoc J* [Internet]. 2010 Feb 23;182(3):235 LP – 242. Available from: <http://www.cmaj.ca/content/182/3/235.abstract>
11. Oliveira A, Kalra S, Wahi G, McDonald S, Desai D, Wilson J, et al. Maternal and Newborn Health Profile in a First Nations Community in Canada. *J Obstet Gynaecol Can*. 2013 Oct 1;35:905–13.
12. Bayleigh Marelj, Local Journalism Initiative Reporter, Vikander T, Chadwick J, Klukas JJ. Several Canadian provinces still issue birth alerts, deemed 'unconstitutional and illegal' in B.C [Internet]. *Indiginews.com*. 2021 [accessed 2021 Oct 15]. Available from: <https://indiginews.com/vancouver-island/status-of-birth-alerts-across-canada>
13. Richardson L. *Twitter.com*. 2021 [accessed 2021 Oct 28]. Available from: <https://twitter.com/RicharLisa/status/1395677976184897540>

14. Public Health Agency of Canada. Social determinants and inequities in health for Black Canadians: A Snapshot [Internet]. Statistics Canada. 2020 [accessed 2021 Oct 28]. Available from: <https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health/social-determinants-inequities-black-canadians-snapshot.html>
15. Public Health Agency of Canada. Social determinants and inequities in health for Black Canadians: A Snapshot [Internet]. Statistics Canada. 2020 [accessed 2021 Oct 28]. Available from: <https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health/social-determinants-inequities-black-canadians-snapshot.html>
16. Bougie O, Yap M., Sikora L, Flaxman T, Singh S. Influence of race/ethnicity on prevalence and presentation of endometriosis: a systematic review and meta-analysis. *BJOG An Int J Obstet Gynaecol* [Internet]. 2019 Aug 1;126(9):1104–15. Available from: <https://doi.org/10.1111/1471-0528.15692>
17. Benard VB, Watson M, Saraiya M, Harewood R, Townsend JS, Stroup AM, et al. Cervical cancer survival in the United States by race and stage (2001-2009): Findings from the CONCORD-2 study. *Cancer*. 2017;123 Suppl 24:5119–37.
18. MacDorman MF. Race and Ethnic Disparities in Fetal Mortality, Preterm Birth, and Infant Mortality in the United States: An Overview. *Semin Perinatol* [Internet]. 2011;35(4):200–8. Available from: <https://www.sciencedirect.com/science/article/pii/S0146000511000462>
19. Catov JM, Lee M, Roberts JM, Xu J, Simhan HN. Race Disparities and Decreasing Birth Weight: Are All Babies Getting Smaller? *Am J Epidemiol* [Internet]. 2015/12/13. 2016 Jan 1;183(1):15–23. Available from: <https://pubmed.ncbi.nlm.nih.gov/26667251>
20. McKinnon B, Yang S, Kramer MS, Bushnik T, Sheppard AJ, Kaufman JS. Comparison of black–white disparities in preterm birth between Canada and the United States. *Can Med Assoc J* [Internet]. 2016 Jan 5;188(1):E19 LP-E26. Available from: <http://www.cmaj.ca/content/188/1/E19.abstract>
21. David RJ, Collins JW. Differing Birth Weight among Infants of U.S.-Born Blacks, African-Born Blacks, and U.S.-Born Whites. *N Engl J Med* [Internet]. 1997 Oct 23;337(17):1209–14. Available from: <https://doi.org/10.1056/NEJM199710233371706>
22. McClain D. What’s killing America’s black infants? *Nation* (New York, NY: 1865) [Internet]. 2017 Feb 15 [cited 2021 Oct 28]; Available from: <https://www.thenation.com/article/archive/whats-killing-americas-black-infants/>
23. Government of Canada, Statistics Canada. A statistical portrait of Canada’s diverse LGBTQ2+ communities [Internet]. Statcan.gc.ca. 2021 [accessed 2021 Nov 15]. Available from: <https://www150.statcan.gc.ca/n1/daily-quotidien/210615/dq210615a-eng.htm>
24. Appendix B: Glossary for understanding gender identity and expression [Internet]. Ontario Human Rights. Queen’s Printer for Ontario [accessed 2021 Oct 18]. Available from: <http://www.ohrc.on.ca/en/policy-preventing-discrimination-because-gender-identity-and-gender-expression/appendix-b-glossary-understanding-gender-identity-and-expression>
25. Pratt-Chapman ML. Implementation of sexual and gender minority health curricula in health care professional schools: a qualitative study. *BMC Med Educ* [Internet]. 2020;20(1):138. Available from: <https://doi.org/10.1186/s12909-020-02045-0>

26. Bauer GR, Zong X, Scheim AI, Hammond R, Thind A. Factors impacting transgender patients' discomfort with their family physicians: A respondent-driven sampling survey. *PLoS One*. 2015;10(12):e0145046.
27. Bauer GR, Scheim AI, Deutsch MB, Massarella C. Reported emergency department avoidance, use, and experiences of transgender persons in Ontario, Canada: results from a respondent-driven sampling survey. *Ann Emerg Med*. 2014;63: 713–720. pmid:24184160
28. Immigration, Refugees, Canada C. Interim Federal Health Program: What is covered [Internet]. Canada.ca. 2012 [accessed 2021 Oct 18]. Available from: <https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/help-within-canada/health-care/interim-federal-health-program/coverage-summary.html>
29. Pottie K, Greenaway C, Feightner J, Welch V, Swinkels H, Rashid M, Narasiah L, Kirmayer LJ, Ueffing E, MacDonald NE, Hassan G. Evidence-based clinical guidelines for immigrants and refugees. *Cmaj*. 2011 Sep 6;183(12):E824-925.
30. Pottie K, Greenaway C, Hassan G, Hui C, Kirmayer LJ. Caring for a newly arrived Syrian refugee family. *CMAJ*. 2016 Feb 16;188(3):207-11.
31. Cook JL, Green CR, De La Ronde S, Dell CA, Graves L, Ordean A, et al.. Epidemiology and Effects of Substance Use in Pregnancy. *Journal of Obstetrics and Gynaecology Canada* 2017;39(10):906–15.
32. Wong S, Ordean A, Kahan M. SOGC clinical practice guidelines: Substance use in pregnancy: no. 256, April 2011. *International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics*. 2011 Aug 1;114(2):190-202.
33. The H.E.R. Pregnancy Program [Internet]. *Catie.ca*. 2021 [accessed 29 September 2021]. Available from: <https://www.catie.ca/en/pc/program/her?tab=how>
34. Lee YW, Saia K. Caring for Pregnant Women with Opioid Use Disorder. *Current Obstetrics and Gynecology Reports* [Internet] 2019;8(1):9–14. Available from: <https://dx.doi.org/10.1007/s13669-019-0255-2>
35. Stone R. Pregnant women and substance use: fear, stigma, and barriers to care. *Health & Justice* 2015;3(1).
36. Kingston D, Heaman M, Urquia M, O'Campo P, Janssen P, Thiessen K, Smylie J. Correlates of abuse around the time of pregnancy: results from a national survey of Canadian women. *Maternal and child health journal*. 2016 Apr 1;20(4):778-89.
37. Long AJ, Golfar A, Olson DM. Screening in the Prenatal Period for Intimate Partner Violence and History of Abuse: A Survey of Edmonton Obstetrician/Gynaecologists. *Journal of Obstetrics and Gynaecology Canada* 2019;41(1):38–45.
38. Taillieu TL, Brownridge DA, Tyler KA, Chan KL, Tiwari A, Santos SC. Pregnancy and Intimate Partner Violence in Canada: a Comparison of Victims Who Were and Were Not Abused During Pregnancy. *Journal of Family Violence* [Internet] 2016;31(5):567–79. Available from: <https://dx.doi.org/10.1007/s10896-015-9789-4>
39. Salmon D, Baird KM, White P. Women's views and experiences of antenatal enquiry for domestic abuse during pregnancy. *Health Expectations* [Internet] 2015;18(5):867–78. Available from: <https://dx.doi.org/10.1111/hex.12060>

40. Ontario Perinatal Record 1 [Internet]. 2017 [accessed 7 October 2021]. Available from: <https://www.pcmch.on.ca/wp-content/uploads/2017/06/OPR-2017.pdf>
41. Duty to report – Ontario Association of Children’s Aid Societies [Internet]. Oacas.org. 2021 [accessed 30 October 2021]. Available from: <http://www.oacas.org/childrens-aid-child-protection/duty-to-report/>
42. Twells LK, Janssen I, Kuk JL. Canadian Adult Obesity Clinical Practice Guidelines: Epidemiology of Adult Obesity. Available from: <https://obesitycanada.ca/guidelines/epidemiology>. Accessed [accessed Oct 9, 2021].
43. Maxwell C, Gaudet L, Cassir G, Nowik C, Mcleod NL, Jacob C-É, et al.. Guideline No. 391-Pregnancy and Maternal Obesity Part 1: Pre-conception and Prenatal Care. *Journal of Obstetrics and Gynaecology Canada* 2019;41(11):1623–40.
44. Incollingo Rodriguez AC, Smieszek SM, Nippert KE, Tomiyama AJ. Pregnant and postpartum women’s experiences of weight stigma in healthcare. *BMC Pregnancy and Childbirth* 2020;20(1)
45. Cornelissen L. Insights on Canadian Society Religiosity in Canada and its evolution from 1985 to 2019 [Internet]. Statistics Canada. Government of Canada, Statistics Canada; 2021 [accessed Dec 10, 2021]. Available from: <https://www150.statcan.gc.ca/n1/pub/75-006-x/2021001/article/00010-eng.htm>
46. 2011 National Household Survey: Immigration, Citizenship, Place of Birth, Ethnicity, Visible Minorities, Religion and Aboriginal Peoples [Internet]. City of Toronto. 2013 [accessed Dec 10, 2021]. Available from: <https://www.toronto.ca/wp-content/uploads/2017/10/9793-2011-NHS-Backgrounder-Immigration-Citizenship-Place-of-Birth-Ethnicity-Visible-Minorities-Religion-and-Aboriginal-Peoples-.pdf>
47. What is disability? [Internet]. Ontario Human Rights. Queen’s Printer for Ontario; 2021 [accessed Feb 18, 2022]. Available from: <https://www150.statcan.gc.ca/n1/pub/75-006-x/2021001/article/00010-eng.htm>
48. New Data on Disability in Canada, 2017 [Internet]. Statistics Canada; 2018 [accessed Feb 18, 2022]. Available from: <https://www150.statcan.gc.ca/n1/pub/11-627-m/11-627-m2018035-eng.htm>
49. Berndl A, Ladhani N, Wilson RD, Basso M, Jung E, Tarasoff LA, Angle P, Soliman N. Guideline No. 416: labour, delivery, and postpartum care for people with physical disabilities. *Journal of Obstetrics and Gynaecology Canada*. 2021 Jun 1;43(6):769-80.
50. Kirkham YA, Ornstein MP, Aggarwal A, McQuillan S. No. 313-menstrual suppression in special circumstances. *Journal of Obstetrics and Gynaecology Canada*. 2019 Feb 1;41(2):e7-17.
51. Kirkham YA, Allen L, Kives S, Caccia N, Spitzer RF, Ornstein MP. Trends in menstrual concerns and suppression in adolescents with developmental disabilities. *Journal of adolescent health*. 2013 Sep 1;53(3):407-12.
52. American College of Obstetricians and Gynecologists. Menstrual manipulation for adolescents with physical and developmental disabilities. ACOG Committee opinion no. 668. *Obstet Gynecol*. 2016;128:e20-5.
53. Secor RM, Fantasia HC. Fast facts about the gynecologic exam: A professional guide for NPs, PAs, and midwives. Springer Publishing Company; 2017 Oct 28.
54. Consent and capacity [Internet]. Ontario Human Rights. Queen’s Printer for Ontario; 2021 [accessed Feb 18, 2022]. Available from: <https://www.ohrc.on.ca/en/policy-preventing-discrimination-based-mental-health-disabilities-and-addictions/16-consent-and-capacity>