McMaster Social Medicine Manual

First Edition

2022

Produced for the Internal Medicine Social Medicine Rotation

Authors

Editors-in-chief: Drs. Inna Berditchevskaia and Xinxin Tang

Chapter Authors:

- Indigenous Health: Dr. Yotakahron Jonathan
    - Edited by: Drs. Claire Bodkin, Kathy Huang, and Angie Woodbury
- Anti-Racism: Surabhi Sivaratnam
    - Edited by: Drs. Christina Ma, Curtis Sobchak, and Achieng Tago, and the UGME Equity, Diversity, and Inclusion Student Advisory Committee
- Refugee Health: Dana O'Brien
    - Edited by: Dr. Angela Carol
- 2SLGBTQ+ Healthcare: Jessica Sadri-Gerrior and Sasha Palmert
    - Edited by: Dr. Jennifer Walker
- Healthcare Considerations for Sex Workers: Stephanie Li
    - Edited by: Dr. Jill Wiwcharuk
- Healthcare for Incarcerated and Detained Patients: Connie Li
    - Edited by: Dr. Fiona Kouyoumdjian
- Opioid Use Disorder: Dr. Jessica Scott
    - Edited by: Dr. Claire Bodkin
- Harm Reduction: Dr. Jessica Scott
    - Edited by: Dr. Claire Bodkin
- Income Supports: Sasha Palmert
    - Edited by: Dr. Dale Guenter
- HIV/AIDS: Jessica Sadri-Gerrior and Dana O'Brien
    - Edited by: Dr. Anna Cvetkovic

Table of Contents

POPULATION HEALTH

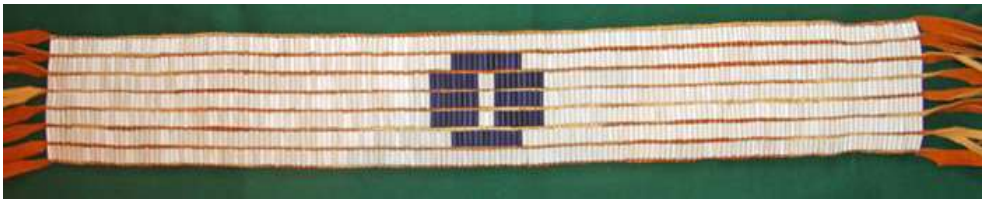
Indigenous Health

Written by Dr. Yotakahron Jonathan, MD, MA, Mohawk
Bear Clan

Indigenous Peoples are not a single, monolithic identity. Each person belongs to a Nation, with its own practices, beliefs, and history [1]. And each individual has their own life experience, which cannot be generalized.

The Dish with One Spoon Territory

Acknowledging the land we live and work on



McMaster University and Associated Sites

The land that McMaster University's three campuses and countless clinical sites currently occupies is unceded traditional Indigenous territory [2]. Much like the vast majority of land in what is now called Canada, this land was and is currently illegally occupied – there were no fair consensual agreements to sell or lease this land to settlers. The importance of acknowledging this fact for settlers goes beyond land acknowledgements, as this is the land that you live and work on [2]. This is the uncomfortable truth, the history of this country that you didn't learn. Which is why it's important to remember in the context of the social determinants of health for Indigenous Peoples. They are living with the very real effects of historical and ongoing colonization [1].

The Dish with One Spoon

The picture above is a replication of the Dish with One Spoon wampum belt. This is an agreement between the Anishnaabe Three Fires Confederacy and the Haudenosaunee Confederacy [2,3]. These two Confederacies each have individual Nations that make up their Confederacy. This agreement encompasses the land that is now called Ontario, Quebec, New York, and Michigan [3]. It is an agreement for this shared space, rooted in Indigenous knowledge: to care for the land and all of creation inside this land [4]. This is how land was envisioned – as a collective responsibility rather than individual ownership.

The visual and oral history of wampum belts were to ensure that everyone understood their meaning. With this wampum belt, the land and all of creation within is considered the dish with one spoon. If you were being asked to share a dish of food with others, you would want to ensure that all parties involved took care of the dish and spoon, not taking more than is needed so that everyone has what they need [2,3].

We Are All Treaty People

Wampum belts were one of the ways some Indigenous Nations ratified their laws. These Nation-to-Nation agreements (treaties) were made between Indigenous Nations well before European contact and continued afterwards too [3].

Not only are Indigenous Nations part of these treaties. Settlers are too. By claiming and being claimed as a Canadian, you are agreeing to uphold these treaty agreements. This is part of your responsibility, as a Canadian.

One such treaty that was made on your behalf is **The Treaty of Fort Niagara, 1764** [3]**.** This treaty applies to every single Canadian and their responsibility to honour their relationship with Indigenous Peoples on the foundation of peace, friendship, and respect.

Indigenous Health

General Context

Indigenous Peoples

- Indigenous Peoples who live in what is now called Canada are a very diverse group of people [1]. There are over 600 different Nations, each with their own language, culture, histories, customs, and traditions [5].
    - Some of these Nations had territories that extended over both sides of the border - the colonial governments placed these artificial boundaries over their territory, separating their Nations, communities, and families. Despite a treaty (The Jay Treaty) that affirms the right for unrestricted border crossing, Indigenous Peoples still feel the impact these colonial governments had in separating Nations and restricting access to traditional territories, disrupting Nations' traditions and cultural practices.
- Before European contact, some of these Nations joined together to form Confederacies. Each with their own foundational history, laws, and customs. These Confederacies have their own name, which is an umbrella term for those Nations within. An example of this is:
    - **The Haudenosaunee Confederacy (inaccurately and historically referred to as Iroquois):** This Confederacy formed back around ~1132 and is made up of Six distinct Nations – Mohawk, Oneida, Onondaga, Seneca, Cayuga, and Tuscarora [3].
- Before the creation of the country of Canada, the British government imposed their dominion over this land, forcibly displacing Indigenous Peoples from their traditional lands in the name of progress and settlement. In order to achieve this, the RCMP was founded with the sole purpose of violently displacing Indigenous Peoples from their lands. They were moved onto tracks of land called "reserves" and laws were created to control both Indigenous Peoples and their lands [1,6,7]. These different laws were combined into The Indian Act, which the new Dominion of Canada's federal government passed into law in 1876 [3]. **It still exists today.**
- One of the uses of the Indian Act is for the federal government to decide who is allowed to be classified as an "Indian" [5, 7] (this terminology is outdated and considered offensive. The term changed to Aboriginal, but this too was seen as offensive. Therefore, the most appropriate term to use is Indigenous when referring broadly to Indigenous Peoples. But if you know the Nation of the people/person you are trying to refer to/discuss, then it is more appropriate to refer to them as their individual Nation).
- The Indian Act adopted the premise that Indigenous Peoples were wards of the state, incapable of managing their own affairs. Therefore, they needed to be managed by the government of Canada [7].
- The categories that the Indian Act use are:
    - **Status First Nation:** Indigenous Peoples who had their names written down on the "Indian Scroll" (or Indian Registry) of who is an "Indian" in Canada [7, 8]. Indian agents (settlers who worked for the federal government and worked to restrict Indigenous Peoples lives by enforcing the Indian Act, especially previous stipulations preventing travel off reserve) travelled across the country in 1851 to create a registry of Indigenous Peoples.
        - **6.1 and 6.2:** This subcategory was designed with the goal of eventually removing the category of Status First Nations. If you are a 6.1, all four of your grandparents are 6.1 "registered Indians" from what is now Canada. If you have a child with someone who is not also a 6.1 (non-Indigenous, or Indigenous from USA), your child would be registered as 6.2 (once you move down in this system, you will never move back up). If you are 6.2 and you have a child with another 6.2 or non-Indigenous person, your children would no longer be considered Status First

Nations. This system was designed for the elimination of Status "Indians" within a few generations. This is recognized as another attempt by the federal government of Canada to remove the "Indian problem" (the Prime Ministers of Canada have historically referred to Indigenous Peoples existing as the "Indian problem" and have worked on finding alternative ways to eliminate Indigenous Peoples or assimilate them into mainstream society so that there is no more "Indian problem") [7].

- **Non-Status First Nation:** This subcategory of Indigenous Peoples whose ancestors did not have their names written down on the Indian Register – they may have been in a different seasonal camp or not on the frequently travelled routes when these Indian agents passed through their territory. This designation of being "non-status" impacts their ability to access any treaty rights.
- **Inuit:** Indigenous Peoples who live throughout what is now considered Northern Canada [7]. They have cultural similarities to Indigenous Peoples who inhabit the Arctic and subarctic regions of the Northern world. They are a distinct group of people from First Nations and Métis, with their own languages, cultures, histories, and teachings. Although the vast majority live in their traditional territories, there are some who live down here (in the South).
- **Métis:** Indigenous Peoples who identify as being a member of a present-day Métis community who has ties to a historic Métis community [9]. They have their own distinct culture and language deprived from this distinct history [9]. It does not encompass anyone with mixed heritage, rather a distinct group who has both a mixed heritage and their own customs and identity separate from their roots of Cree and French [9].

- These are very simplistic ways in which the federal government has tried to control the ways in which they classified Indigenous identity [6, 7].
- These categories are harmful to Indigenous Peoples. A few of the ways in which this system is harmful is:
  - This is how the Canadian government enforces their concept of Indigeneity onto Indigenous Nations and Indigenous Peoples, to this day [7].
  - This relied on ancestors being tracked and written down in order to be considered Indigenous.
  - This has nothing to do with each Indigenous Nations' own determination and their different conception of Nationhood [7].
  - This was only passed down through the fathers' lineage
    - When you register your child at birth, the default is to register your child under their father
    - This does not recognize that not all Nations are patrilineal, some are matrilineal. But the federal government does not recognize this.
  - This was used to discriminate against women [7]. If an Indigenous woman married someone who was not Indigenous, she would lose her status. If an Indigenous man married someone who was not Indigenous, the non-Indigenous woman would gain Indigenous status (which was seen as a negative thing for her) [1,5,6].
  - The Indian Act allowed for the removal of status (disenfranchisement) of Indigenous people who: went to war, went to post-secondary, became a lawyer or doctor [4,7].
  - It continues to ignore the ways in which Indigenous Nations determine identity and continues to perpetuate a system of elimination rather than being inclusive and encompassing the complexities of Indigenous identity.

This system is still in place today – The Indian Act still exists and impacts Indigenous Peoples lives today. Canada is the only country in the world that continues to have legislation that controls the lives of a subsect of people within their borders in this way.

Geography

- When the Indian agents (sometimes a role given to the local physician) went around registering Indigenous Peoples, they did this not only to track Indigenous individuals but to restrict their movement – this was through the creation of the reserve system by the British government, which was later ratified into legislation (The Indian Act) once Canada came into existence [7].
- This was a system designed to remove Indigenous Peoples from their traditional territory and onto smaller plots of land, to make way for settlers to "settle" on this land.
- Reserves were often removed from areas where the federal government wanted to create cities. This was strategically done so that Indigenous Peoples would be removed and isolated from mainstream society [1,7].
- There was little planning into the infrastructure of reserves and no planning of the continuation and expansion of reserves to fit the population size (the federal government did not expect the population size to grow – let alone be the fastest growing population today). This means that the reserves do not have updated infrastructure that settler cities and towns have such as water lines with drinkable tap water, septic systems, garbage, and recycling facilities [1,6]. It also explains why there is a housing crisis on reserves – there is little room to expand to meet the needs of the population.
- **Once amendments were made to the Indian Act in the 1960s, Indigenous Peoples were allowed to leave their reserve.** Prior to this, they needed permission from the Indian agents.
- Due to various factors (such as overcrowding on reserves, limited job opportunities, having to leave for educational training, being forcibly removed from their communities due to the child welfare system and the Indian Residential School systems) – the majority of Indigenous people living in Canada live "off reserve", in cities and communities all across the country [1,5,6].
- Since mobility across the country is no longer restricted due to the Indian Act, do not assume that the Indigenous patient you are treating is from a local Indigenous community. More than half of all Indigenous Peoples living in Canada live in urban settings [6].

Indigenous Health

Context for Patient Care

Indigenous Patients

- Indigenous Peoples are as diverse as any other group of people. As such, you won't always be able to tell if your patient is Indigenous. Their name, their outward appearance, their location – these things might not tell you whether or not your patient is Indigenous.
- The best way to elicit this information is through the history taking process. And it should only matter within your history taking if it is relevant to the reasons for the patient visit.
- However, if you are seeing a patient for only one encounter, their Indigeneity might not be relevant to the care you provide them. Therefore, it would be inappropriate for you to probe about their Indigeneity, especially if it is just for your own curiosity.
- It might be relevant to their visit, particularly if you are prescribing them a medication in an outpatient setting, which is when it would be appropriate to ask. Depending on the government has classified their Indigeneity, some Indigenous Peoples have limited coverage of some medications through a federally run program called "Non-Insured Health Benefits" (NIHB) [1,6].
- If you are prescribing a medication to a patient, you should always ask about drug coverage. This would be when you could elicit the information from your patient – whether or not they are Indigenous, you should always ask about drug coverage.
- For Indigenous patients who are covered by NIHB, they may refer to it in different terms, such as referring to it as "Indian Affairs" coverage. If they are covered by NIHB, see the next section as it is important for your patient to receive the medication you are prescribing.

Non-Insured Health Benefits

- This is a federal program that covers some medications, medical equipment, and psychotherapy for status First Nations and Inuit people – it excludes non-status First Nations and Métis [1,6,10].
- As the website states, the federal government wants "physicians and pharmacists [to] use this list to select the most optimal and cost-effective drug therapy."
- NIHB has a database that can be assessed in two ways:
    - **Searchable database:** This remains up to date, but it is not user friendly.
    - **PDF file:** Can be downloaded on a device, which allows the user to search for key terms.
- There are many problems with this program, such as:
    - Medications and treatments can be denied coverage [1,6]. This can be for numerous reasons, such as:
        - The NIHB employees are not medically trained and follow an algorithm for what should be prescribed for what condition. As we know, we are treating patients and their symptoms, which sometimes require off-label use. This leads to physicians having to advocate for their patients, which is additional uncompensated work (such as having to fill out paperwork for special permission formulary use).
        - The medication prescribed is a brand name, or the formulary wants alternative medications within the similar class to be tried first (as it would be more cost-effective). This sometimes leads to medications being denied by NIHB without a reason given. This leads to confusion in communication amongst pharmacists, patients, and physicians. Examples of where this causes issues:
            - The pharmacy wasn't made aware of the reasoning for rejection and not all

pharmacists know about NIHB, which can lead the patient to not receiving their medication at all. Patients then can be labelled as non-compliant with their medications, when it is not their fault – it is our job to ensure our patients have access to the medications we prescribe.
        - Patients are made to pay for their medication. They were not told by their physician that this would be a possibility, and if they are used to having medications covered, they may not wish to buy medications (or cannot afford to). This often leads to patients being labelled as non-compliant, when it is not their issue – it is our job to ensure our patients have access to the medications we prescribe.
        - Physicians are not aware of NIHB (the formulary and the special permission forms). This often leads to the problems listed above. We often label patients as non-compliant with their medications, not taking accountability or responsibility for how we could have prevented these types of miscommunications. **It is our job to ensure our patients have access to the medications we prescribe.**
- Ways to prevent situations like the real-life examples listed above is to ensure we check the NIHB formulary, fill out the special permission forms, and (sometimes) a quicker way around this is to write "no substitutions" on the prescription.
- You may have to advocate for your patients to receive the medication and treatment that you want them to receive. This work is done by many Indigenous physicians and settler physicians.
- Being a settler means you have certain privileges. And being a settler physician within our medical system, you can use your power and privilege to advocate for Indigenous patients. Some excellent examples of this are:
    - Dr. Mike Kirlew: advocated to the federal government for rural/remote Indigenous patients to be allowed a family member to come along to medical appointments as a support – the government would only cover the individual to travel alone. In situations like "confinement" for birth (the practice of mandating Indigenous pregnant patients to leave their community 4 weeks prior to their birth to stay in a hotel/hostel near the hospital), or medical appointments in bigger cities where they might not speak the language, Dr. Kirlew saw how this impacted Indigenous patients and petitioned the government to change their policy.
    - Dr. Samir Shaheen-Hussain (A Hand to Hold): Similarly, Dr. Shaheen-Hussain had Indigenous pediatric patients in the ED who were sent via medevac alone, often hundreds of kilometers from home. These children were needing emergency care, distraught from not having their parents, and sometimes didn't speak English (or hadn't started to learn how to speak yet). Seeing this as a huge problem, Dr. Shaheen-Hussain started to work with Indigenous people to advocate for change.

Cultural Practices

- These are too diverse to generalize for each patient, as not all Indigenous people have the same cultural or spiritual practices, even within the same Nation, community, or family [1].
- Some of these practices are <u>closed</u> cultural practices, which means since you are not part of the culture, you aren't allowed access to the information. This is something you need to respect, if your patient is unwilling to disclose information regarding their cultural practices (ceremonies, traditional medicines, foods).
- There are some cultural practices that could be relevant to your patient. Some of these will matter more on certain rotations, or fields of medicine, such as:

    - **On L&D**: some Indigenous people have cultural practices that involve the placenta and umbilical cord. Support Indigenous patients by asking them if it is important to keep these items and find appropriate containers (some hospitals are used to this and supply containers, some families bring containers with them, as they anticipate being able to take these items home).
    - **End of life care**: it might be important to your patient for family, friends, and spiritual leaders to be present at this time. Advocating for your patient to have as many visitors as feasible is a way to ensure their cultural practices are honoured.
- There are also some practices that you can ensure to ask Indigenous patients about, if relevant, such as:
    - **Smudging**: this is a cultural practice that some Indigenous Nations and their members participate in. It involved smoke, as they are burning traditional medicines for ceremonial purposes. Some hospitals have a room that is specifically ventilated for smudging to take place. You can find out if this is offered at your institution and advocate for your patient, allowing them this sense of cultural safety within the hospital.
    - **Cultural/traditional food and medicines:** advocating for your patient to have these items is important. This is part of their overall health and well-being - taking care of their spiritual, mental, physical, and emotional health. Some of these are closed cultural practices. They are often distributed by traditional medicine practitioners, who have spent years of training within their communities to be able to provide these forms of healing. Questioning their methods is harmful as you are not recognizing the knowledge and expertise they hold. They are doing their best to care for their Indigenous patients, just as you are.
- Most Indigenous Nations prioritize oral history and storytelling [1,6]. This might be reflected in how some Indigenous patients answer your questions. They might tell you the story of how they ended up with x or y symptom, rather than a simple yes or no answer. If you do not allow them the space to tell you what they believe is important for you to know, you could miss out on key information.

Trauma-informed Care

- Both historically and ongoing within Canadian society, Indigenous Peoples have experienced racism, harm and sometimes death by settlers, by the federal government, by the medical system, the education system, the police force, etc. [1,6]. The experience of surviving within a colonial system can be traumatic. This trauma is not only felt and experienced by individuals, but it is passed on within generations.
- Within the Canadian healthcare system, there were segregated hospitals for Indigenous patients, forced displacement for medical treatment, medical experimentation, forced sterilization [10], and assimilation tactics such as restricting Indigenous cultural practices [1,6].
- This is not just in the past. The last documented case of forced sterilization of an Indigenous woman in Canada, without her consent, was in 2019 [10]. Indigenous patients still need to leave their communities to seek medical treatment, some traveling upwards of 12 hours without guaranteed transportation home (the federal government will cover the cost of travel to medical facilities but not home – this often leaves Indigenous people stranded after their treatment concludes)
- This understandably has led to a reasonable amount of caution and mistrust of these potential places of harm. Therefore, we need to acknowledge that it might have taken a lot of courage for an Indigenous patient to seek your help within health care.
- This is why it is also important that as settlers providing healthcare within Canada, you begin to learn the history of this country, the harms caused to Indigenous Peoples, and your positionality

to this colonial history, but why it is important to learn to incorporate a trauma-informed care lens to your patient encounters. This can and should be used with all your patients.

- A practical tip for approaching patient encounters in a trauma-informed way is to ask for consent before every single step and speaking aloud what you are about to do next – such as, "I need to take your blood pressure, is it okay if I do that next?" If someone has been traumatized previously in healthcare, this approach to their care will reduce the likelihood of re-traumatization. This is something that can be done with every patient, not just Indigenous patients.

Connection

- Not all Indigenous people are from the area in which you currently are – this can be a harmful assumption to make. Particularly if their displacement from their traditional territories was not by choice, but by force (child welfare system, Indian Residential School system).
- Assuming that an Indigenous patient is "well connected" to the appropriate services can be a serious and common pitfall. Indigenous people, much like settlers, move to different cities, or across the country.
- It is important to ensure that your patient is connected to services that are designed to help them. Here is a list of local agencies in a few of the cities that we all rotate in, that you might direct your patient to:
    - **Hamilton**
        - **De dwa da dehs nye>s Aboriginal Health Centre**: If your patient is in need of a family doctor or traditional medicine practitioner, you can call them at 905-544-4320. They also provide health education, mental health and addictions support
        - **Aboriginal Patient Navigator:** A helpful resource that aims to help Indigenous patients and their families navigate their healthcare journey within Hamilton. They can be reached at 905-544-4320 ext. 242
        - **JCC Aboriginal Patient Navigator:** Like above but with a focus on their cancer journey. Can refer or receive more information by calling 905-521-2100 ext. 64315.
        - **Makayla's Room - MUMC**: A memorial space within MUMC for Indigenous patients and families to retreat to, and a space for settler patients and families to learn about and participate in certain Indigenous crafts and culture.
        - **Hamilton Regional Indian Centre:** A non-profit cultural centre for Urban Indigenous people with numerous supports and programs, such as cultural programming, healthy living programs, and programs for all ages. If your patient is new to the area, they may find support and resources here.
        - **Hamilton Health Sciences:** Smudging policy has been developed for all hospitals. Contact Psycho-Spiritual Care to arrange for a patient.
        - **Indigenous Housing Services Department:** A community hub that combines multiple housing programs and services to meet the needs of the Urban Indigenous population in Hamilton. They also have a food security program. Patients can self-refer at 905-544-4320 ext. 450.
    - **Niagara Region**
        - **De dwa da dehs nye>s Aboriginal Health Centre**: Along with healthy living and cultural programming, if your patient needs a family doctor or traditional medicine practitioner, you can call them at 1-877-402-4121.
        - **Fort Erie Native Friendship Centre:** A community hub for cultural programming and supporting Indigenous members of the area. Offers help with transportation to and from medical appointments and hospital visits. Can be reached at 905-871-8931.

        - **Niagara Regional Native Centre:** A community hub for Indigenous community members with housing supports, healthy babies/healthy children programming, mental health programming, lifelong care, and a Health Outreach Worker. They can be reached at 905-688-6484.
    - **Kitchener/Waterloo**
        - **Anishnabeg Outreach:** A non-profit organization that provides culturally appropriate services to Indigenous community members of Kitchener. Some services include mental health programming, employment, and traditional medicines. Can be reached at 519-208-5333.
        - **Healing of the Seven Generations:** Serving Indigenous Peoples within the KW region. They host community events and have programming for all ages, such as their senior's program and food program. They can be reached at 519-570-9118.
        - **Southwest Ontario Aboriginal Health Access Centre:** They support Indigenous patients all throughout Southern Ontario. They have numerous services and programs, such as dental, midwifery, mental health, nutrition, Indigenous culture, and traditional medicines to name a few! They can help Indigenous patients with accessing a primary care provider. For patients in the KW area, they can be reached at 226-476-3672

Indigenous Health

Deeper Learning

Cultural Safety as a Patient Safety Issue

- Try not to fall into the thinking that cultural competency training is a one-time event. Being culturally competent and safe for Indigenous patients will be a lifelong commitment.
- Evident from the current stories we hear about racism within the healthcare system, we must ensure that we make this commitment not only for Indigenous patients, but our Indigenous colleagues.
    - The resources below discuss examples of Indigenous patients dying due to racism, discrimination, and the unconscious bias healthcare workers have against Indigenous Peoples. Working towards ensuring our healthcare system and all those within it are culturally safe, we can ensure Indigenous patients not only feel safer, but can safely navigate receiving healthcare.
- As you continue on this path of learning, you'll shift from mere awareness of the issues that Indigenous Peoples face, to being more culturally competent and safe.
- This will only happen if you continue learning, unlearning, and relearning. No one can do this work for you, you must put in the effort to do this.
- You will make mistakes. We are human, we all make mistakes. But you can learn from these mistakes and continue to do better.

Resources

- Here are just a few resources to start you on the path of learning:
    - **Online Resources:**
        - **Indigenous Cultural Safety Collaborative Learning Series:** Webinars that delve deeper into Cultural Safety and topics about Indigenous health

- **Royal College Indigenous Health Primer:** Published in 2019, this 85-page document is designed by healthcare workers for healthcare workers to provide basic background knowledge in caring for Indigenous Peoples
- **First Peoples, Second Class Treatment:** Discusses the role of racism in the health and well-being of Indigenous Peoples in Canada
- **Bringing Reconciliation to Healthcare in Canada:** a 28-page report that developed wise practices for healthcare leaders

- **Books:**
  - **Fighting For a Hand to Hold:** Dr. Samir Shaheen-Hussain writes about the Canadian medical establishment's role in colonial genocide
  - **Structures of Indifference:** Mary McCallum and Adele Perry write about the life and death of Brian Sinclair
  - **Seven Fallen Feathers:** Tanya Talaga examines how systemic racism contributed to the deaths of seven Indigenous youth
  - **Separate Beds:** Maureen Lux writes about the shocking history of segregated hospitals for Indigenous Peoples in Canada

- **Training:**
  - **University of Alberta:** A 12-lesson massive open online course that explores Indigenous histories and contemporary issues in Canada
  - **San'yas: Indigenous Cultural Safety Training:** an online training program (accredited for up to 16 Mainpro+ type credits) for cultural safety with Indigenous patients
  - **Cancer Care Ontario:** 13 courses about various topics on Indigenous health, history, and cultural competency. These are self-paced, free of charge courses that are certified for up to 13 Mainpro+ credits

- **Reports to Read:**
  - **Royal Commission on Aboriginal Peoples (RCAP):** a 5-volume report with over 3,000 recommendations regarding all aspects of Indigenous Peoples lives and the ways that we have been harmed, how we can restructure our relationship with one another, improve Indigenous Peoples lives, and commit to change for the future. It was published in 1996 and at the time, the only recommendation that was taken up by the federal government was National Aboriginal Day which was established in 1996. It is on June 21st of every year and is now called National Indigenous Peoples' Day.
  - **The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP):** adopted by the UN General Assembly in 2007, this non-binding international instrument is a 30-page document outlines that outlines the minimal standards for survival, dignity, and well-being of Indigenous Peoples in the world. Canada initially voted against the endorsement of UNDRIP (along with the USA, New Zealand, and Australia – the four countries in the world that have similar colonial histories that the Indigenous Peoples living there have experienced). Canada finally officially endorsed UNDRIP in 2016.
  - **The Truth and Reconciliation Commission's Calls to Action (TRC):** The Truth and Reconciliation Commission was established to collect the stories of survivors of the Indian Residential School system in Canada. Published in 2015, the TRC has numerous reports and Calls to Action. On their website, they have many

resources and educational material to increase awareness and understanding of the violence experienced in these "schools" and the lasting impacts today.

- **Murdered and Missing Indigenous Women and Girls (MMIW):** in 2019, a National Inquiry published their final report about the staggering rates of violence against Indigenous women, girls, and 2SLGBTQQIA people. It is in two volumes, along with 231 individual Calls for Justice.
- **Coroner Report into the Death of Joyce Echaquan:** This 2021 report found that 37-year-old Joyce Echaquan died in 2020 due to racism. The report states "we have witnessed an unacceptable death and we must ensure that it was not in vain and that we learn from this tragedy as a society. It is therefore unacceptable that broad swaths of society deny a reality that is so well documented."
- **Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Quebec:** A 2019 report that concluded that cultural barriers and prejudice in the healthcare system in Quebec were having "dire consequences" for Indigenous people. The numerous problems detailed in this report included delayed diagnosing and the failure of medical staff to order necessary exams or medications.
- **Ignored to Death:** The Final Report of the Inquest into the Death Brian Sinclair, after he presented to the ER in Winnipeg to get his catheter changed, was in distress but ignored for 34 hours by numerous hospital staff, and died because of racism. The assumptions that these healthcare workers have about Indigenous Peoples contributed to the death of Brian.
- **Jordan's Principle:** In 2005, 5-year-old Jordan Anderson died in the hospital waiting for the chance to go home. There was a dispute between the provincial and federal governments over who was financially responsible for his medical care upon discharge. After the Caring Society produced a report and recommendations, this Principle was passed, ensuring that all First Nations children living in Canada can access the products, services, and supports they need, when they need them.
- **Forced and Coerced Sterilization of Persons in Canada:** The Standing Senate Committee on Human Rights wrote this 2021 document discusses the ongoing forced sterilization of Indigenous women in Canada with the last documented case made public was in 2019.

Anti-racism

This primer provides learners with practical tools on how to respond to patient-based and healthcare provider-based racism, as well as how to support learners navigating a difficult situation.

Medical Racism Primer

Within the medical profession, racism, implicit bias, and prejudice can negatively impact patient outcomes:

- In Manitoba, the infant mortality rate for Indigenous peoples is almost double that of non-Indigenous people.[5]
- Persistent sex and race-based disparities exist with respect to heart treatment, with Black patients statistically less likely to have a heart specialist assigned to them or an intervention performed to evaluate the blood supply to their hearts.[6]
- A substantial number of health care professionals hold false beliefs about biological differences between racial groups, which predicts racial bias in pain perception and treatment recommendation accuracy.[7]
    - E.g. Todd et al. found that Black patients were significantly less likely than white patients to receive analgesics for extremity fractures in the emergency room (57% vs 74%), despite having similar self-reports of pain.[8]

"I Didn't Know What to Say": Responding to Racism

Combating Health Care Provider Bias[9]

- Separate the person from the behavior (e.g. "that was a racist remark" vs "you are racist")
- Ask questions about the behavior using "how" or "what made you…" rather than "why…" as this can make folks defensive
- Use "I" statements describing how the action affected you or refer to the action indirectly (e.g. "when x happened, I felt y")
- Note your tone of voice, body, language etc., when responding – what is your intention and goal for your outcome? How can your tone and body language help you achieve this?

Supporting Learners[10]

- A simple "check-in" goes a long way:
    - *E.g. "That was a difficult encounter … how are you feeling?"*
- Involve the trainee in decision-making about next steps
    - *E.g. "I can understand how continuing to work with patient X could be difficult. We have a couple of options and I'd like to get your input on which one feels right to you."*
- Encourage reporting incidents and empower trainees to speak up
    - *E.g. "I want to hear when things like this happen. It's important that everyone feels safe and comfortable here."*
- In the face of racism from colleagues (e.g., from same level of training, and those are higher levels of training)
    - *E.g. "What X said was inappropriate and not acceptable. How can I support you right now and in the future?"*

Language Primer

- Privilege: unearned advantages enjoyed by one group or class of people, at the disadvantage of others.[1]
- Oppression: the combination of prejudice and institutional power which creates a system that discriminates against some groups, while benefiting other groups.[2]
- Intersectionality: a framework that conceptualizes a person, group of people or social problem as being affected by a number of discriminations and disadvantages, due to overlapping identities and experiences.[3]
- Race: a socially constructed way of grouping people, based on skin color and other apparent physical differences, which has no genetic or scientific basis; this social construct was created to justify the oppression of Black and Indigenous people, and People of Colour.[4]

Combating Patient Bias

Framework to respond to patient bias: ERASE[11]

- **E**xpect that such events will happen and prepare accordingly.
- **R**ecognize the mistreatment (e.g. microaggressions, "compliments")
- **A**ddress the situation in real time.
- **S**upport the learner after the event.
- **E**stablish/Encourage a positive culture.

Examples of ERASE framework

- Addressing derogatory comments
    - "We expect both patients and providers to be treated with respect in this clinic/unit. We cannot tolerate that kind of language."
    - "That type of comment is inappropriate. Please refrain from speaking that way to our staff."
- Addressing "complimentary" comments
    - "Mr. Y, Dr. A is a very smart and skilled physician. That's far more important than her looks."
- Addressing "race-based" comments
    - Post-encounter
        - "That was a difficult encounter…how are you feeling?"
        - "I want to hear when things like this happen. It's important that everyone feel safe and comfortable here."
    - During encounter
        - "I am not sure I understand what you were saying. Could you clarify that statement?"

Microaggression Toolkit

- **Microaggressions** are statements, behaviors, and environmental indignities, whether intentional or unintentional, that communicate negative or denigrating racial, gender, sexual-orientation, and religious slights and insults to the target person or groups.[1,2] Such indignities communicate hostile, derogatory or negative messages to target persons based solely upon their marginalized group membership.[12]

Additional Resources

This section includes resources on understanding racism and privilege as a whole, including compelling videos and documentaries, as well as articles about racism and anti-racist practices in a healthcare-specific context.

Understanding Racism and Anti-Racism

- Documentary film: The Skin We're In - Desmond Cole https://gem.cbc.ca/media/firsthand/episode-14/38e815a-00be178daef
- Documentary film: Remember Africville - National Film Board https://www.nfb.ca/film/remember_africville/?fbclid=IwAR0tx3dOtuo3y84ovw6SlPDO0fOPH44xdJLdgTKkwTH2BZ7cCXlmbn27M0U
- Documentary film: 13th - on Netflix

Understanding Privilege

- Video: Privilege 101 - The Coin Model of Privilege - Stephanie Nixon https://www.youtube.com/watch?v=FvlEVEW1Sp8
- Article: The coin model of privilege and critical allyship: Implications for health - Stephanie Nixon https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-7884-9
- Reading and self-quiz: White Privilege: Unpacking the Invisible Knapsack - Peggy McIntosh
- Video: Why are White People So Bad at Talking About Race? featuring Dr. Robin DiAngelo https://www.refinery29.com/en-us/why-are-white-people-so-bad-at-talking-about-race
- Webinar**:** Privilege, Oppression and Allyship: An Introduction for Health - Stephanie Nixon https://www.youtube.com/watch?v=yiWZK2AxF7M&feature=youtu.be

Racism in Healthcare, and Health Equity

- Medical Education Resources: Anti-racism in Medicine Collection - https://www.mededportal.org/anti-racism
- Video: Tools for Achieving Health: Allegories on 'Race' and Racism - Dr. Camara Phyllis Jones https://www.youtube.com/watch?v=r3LfB7hoM9k
- Webinar: From Stories to Action: Addressing Anti-Black Racism in Healthcare - Dr. Ameil Joseph, Sarah Adjekum, Lyndon George and Dr. Madeleine Verhovsek https://www.youtube.com/watch?v=6lIRC6XkhB8&feature=youtu.be
- Video: The Problem with Race-Based Medicine - Dorothy Roberts https://www.ted.com/talks/dorothy_roberts_the_problem_with_race_based_medicine/up-next?language=en
- Article: Uprooting Medical Violence: Building An Integrated Anti-Oppression Framework for Primary Health Care - Dr. Nanky Rai

https://docs.google.com/document/d/1fVkVw2vOSF_TowE3cmfo_wM4s6_Yp74Lzhz2sUUj4iA/edit

- Video: Race, Racism and Health - Dr. Stephen Nelson (University of Minnesota's Pediatric Grand Rounds) https://www.youtube.com/watch?v=Lz9PddgYYic
- Understanding our implicit biases as healthcare professionals - https://implicit.harvard.edu/implicit/canada/takeatest.html
- " Data & Sovereignty: Resisting Colonial Logics For Racial Justice" -- https://www.macvideo.ca/media/Data+%26+Sovereignty/1_2gxgha0l
- Black Maternal Health disparities - https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html
- Racial bias in pain assessment - https://www.aamc.org/news-insights/how-we-fail-black-patients-pain ; https://www.pnas.org/content/113/16/4296

Refugee Health

Overview of clinical considerations when interacting with refugee patients in Canada.

Refugees in Canada

- **Refugee and Humanitarian Resettlement Program**
  - Branch of the refugee system for individuals in need of protection who are currently **outside Canada**
  - Refugees are identified by the **United Nations Refugee Agency (UNHCR)** and private sponsors
  - Resettlement is assisted by private sponsors (including sponsorship agreement holders), Groups of Five, or community sponsors
- **In-Canada Asylum Program**
  - Branch of the refugee system for individuals making refugee claims while already present **in Canada**
  - Eligibility of claims are assessed and must meet certain conditions including
    - Lack of previous convictions for serious criminal offenses
    - No previous claims denied by Canada
    - Arrival from a location other than the Canada/US border
  - If eligible, claims are referred to the **immigration and refugee board of Canada** for decision
- **Interim Federal Health Program**
  - Temporary healthcare coverage for refugees and refugee claimants in Canada
  - Consists of
    - **Basic coverage:** Similar to provincial health insurance coverage
      - In- and outpatient hospital care, care by licensed healthcare professionals, and laboratory, diagnostic, and ambulance services
    - **Supplemental coverage:** Similar to provincial coverage for those receiving social assistance
      - Some vision and urgent dental care, home and long term care, assistive devices, medical supplies, and equipment, and some services from allied health
    - **Prescription drug coverage:** Similar to provincial coverage for those receiving social assistance
      - Medications on the provincial drug plan formulary
    - **Coverage for the Immigration Medical Exam:** Refugees must undergo the IME, including a physical and mental exam, medical history, labs and diagnostic tests, and a medical assessment of records

Definitions

Refugee: A person who has left their home country and cannot return due to threat of persecution for their race, religion, nationality, social group membership, or political opinion (1, 2)

Sponsorship Agreement Holders: groups who regularly work with the government of Canada under signed agreement to help sponsor refugee resettlement. (1)

Groups of Five: A collection of five or more Canadian citizens or permanent residents who live in the same community where a refugee identified by UNHCR will settle and sponsor them, generally for a period of one year (3, 4)

Community Sponsors: Community organizations that agree to sponsor refugees identified by UNHCR , generally for a period of one year(5)

Interacting with Refugee Patients

- **Language Barriers**
  - Set-up and effective communication (particularly important with older adults)
    - Reduce distractions by sitting face-to-face and limiting background noise
    - Use visual aids in explanations to enhance understanding
    - Move in a logical topic-by-topic order to clearly explain key points and reduce confusion
    - Ask patients to explain information in their own words to verify their understanding
  - Interpretation
    - Options
      - **Professionally trained medical interpreters**
        - High accuracy
        - High confidentiality
        - May be trained in cultural interpretation
        - High cost
        - Difficult to access
      - **Telephone interpretation services** or **Ad-hoc interpretation** by individuals with no training
        - Both are lower accuracy (lack of facial expression in phone conversations, lack of training in ad-hoc)
        - Cost per minute for phone interpretation
        - Easier accessibility
      - **Family and friends**
        - Poor accuracy
        - Poor confidentiality
        - Very easily accessible
    - Working with an interpreter
      - Establish the intent of the interview and confidentiality requirements with the interpreter prior to the conversation
      - Position the interpreter next to or slightly behind the patient to emphasize physician-patient connection
      - Explain the role of the interpreter to the patient
      - Speak to the patient rather than the interpreter

- **Trauma and Violence Informed Approach**
  - Generalist practice
    - Approach all individuals as though they may have experienced trauma
    - Acknowledge and account for the impact of trauma on physical and mental health and well-being, and on coping strategies
  - Preventing re-traumatization
    - Work to prevent re-traumatization in all interactions
    - Avoid triggering interventions
  - Foster safety
    - TIVA has a goal of building emotional, physical, psychological, interpersonal, social, cultural, and systemic safety

        - Utilize cultural competence, accounting for patients' specific personal and cultural contexts
    - Continual growth and community building
        - Shift focus to center strengths instead of solely pathology
        - Incorporate and work together with patients in decision making including for treatment and care
        - Provide opportunities for choice and collaboration
    - In the context of refugees an awareness of culture, history, and gender issues is important
        - Sensitivity with respect to culture, ethnicity, and identity, and to past trauma associated with marginalization, is critical

- **COVID-19**
    - Refugees have been heavily impacted by the pandemic, with higher recorded rates of infection despite lower access to and rates of testing
    - Challenges such as increased financial insecurity, language barriers in the context of virtual care, and difficulties accessing and utilizing technology have exacerbated pre-existing barriers, while access to health care and social supports has become more limited
    - Mitigating these barriers requires an interdisciplinary and case-by-case approach, incorporating patient input to center their priorities
    - Recommendations to address some of these barriers to care include
        - **Encouraging COVID-19 prevention**
            - Promote masking, distancing, hand hygiene, and other public health measures
            - Support education regarding and access to vaccination
        - **Promoting access to COVID-19 testing, care, and immunization**
            - Advocate for better access to vaccination and community access to testing and care
            - Address social needs such as food, income, and safe housing to support self-isolation
        - **Supporting women, children, and families**
            - Connect women, children, and families to specific necessary supports
            - Look out for signs of domestic violence and mental illness
        - **Addressing stress and mental health**
            - Discuss social stressors and connect individuals to relevant resources
            - Collaboratively explore options for mental health support
        - **Recognizing the potential and limitations of virtual care**
            - Be aware of potential limitations to privacy and to the ability to access or use technology
        - **Being alert to social needs and advocating for individual and systems-level change**
            - Provide information and access to supports to address identified social needs
            - Advocate for better access to care and strengthened social support regardless of immigration status

Considerations in Refugee Evaluations

- **In addition to focused investigations targeting any presenting complaint…**
- **First visit**
    - General
        - Date of arrival
        - Languages
        - Country of origin
        - Supports
        - Settlement/refugee claimant worker
        - Refugee claimant hearing date
    - Orientation
        - Orient to clinic appointments and the health system
        - Discuss confidentiality
    - Psychosocial
        - Education
        - Past occupation(s)
        - Housing
        - Migration/displacement history
        - Be aware of potential for PTSD*
        - Depression screen (if access to an integrated treatment program is possible)*
    - Patient Education
        - Nutrition screening and counselling
            - Promote breastfeeding
        - Exercise programs, Promote active living
        - Screen for contraceptive and emergency contraception needs**
        - Home visits for high-risk mothers (infants under 3)
    - Physical
        - Fever—be alert for malaria if patient is from an endemic area
    - Screening Investigations
        - CBC with differential: iron-deficiency screening in **children 1-4 years** and **females**
        - Varicella serology: for individuals from **tropical countries**
            - May include individuals from the Caribbean, South or Southeast Asia, Central or South America, the Central Middle East, Sub-Saharan Africa, or North Africa
        - HIV: for individuals from areas with **high prevalence (>1%)**
            - May include individuals from the Caribbean, South or Southeast Asia, or Sub-Saharan Africa
        - Tuberculin Skin Test: for individuals <50 years from countries where **TB is endemic**, as well as adults with **increased risk of active TB**
            - May include individuals from South or Southeast Asia, Eastern Europe, Central or South America, Sub-Saharan Africa, or North Africa
        - Hep B (sAg/sAb/cAb): for individuals from areas with **high seroprevalence (≥2% HBsAg positive)**

            - May include individuals from South or Southeast Asia, Eastern Europe, Central or South America, the Central Middle East, Sub-Saharan Africa, or North Africa
        - Hep C antibody: for individuals from areas with **prevalence ≥3%**
            - May include individuals from South or Southeast Asia, Eastern Europe, Sub-Saharan Africa, or North Africa
        - Strongyloidiasis serology: for individuals from migrant populations with **high prevalence**
            - Include individuals from Southeast Asia, Sub-Saharan Africa, or North Africa
        - Schistosomiasis serology: for individuals from migrant populations with **high prevalence**
            - Include individuals from Sub-Saharan Africa or North Africa
    - Immunizations
        - **Children (age-dependent):**
            - DTP-aP
            - MMR
            - HPV
            - Varicella
        - **Adults:**
            - DPT
            - MMR
            - Varicella

- **Second visit (2-7 days)**
    - Physical
        - Visual acuity screening***
        - Dental mouth exam (NSAIDs for pain, refer for pathology/pain)***
        - Nutritional status
        - Fevers
        - Scars/skin lesions
        - Finger clubbing
        - Wheezing
        - Heart murmurs
        - Lymphadenopathy
        - Organomegaly
        - Limb weakness
    - Screening Investigations
        - Screen for obesity
        - LDL/cholesterol: for **men >35 years** and **women >45 years**
        - Be alert for social isolation of **pregnant women***
        - Fasting glucose: for individuals **>35 years** from **ethnic groups at high risk** of type 2 diabetes
            - May include individuals from the Caribbean, South Asia, Central or South America, the Central Middle East, Sub-Saharan Africa, or North Africa
        - CXR: if TST **>10mm**

- **Third Visit**
  - Orientation
    - Verify patient links to local resources
  - Psychosocial
    - Be alert for:
      - Adjustment stress
      - Child neglect
      - Intimate partner violence*
      - Depression
      - PTSD
  - Patient Education
    - Diet counselling
      - Iron deficiency
      - Diabetes
    - Dental care
    - Achieving adequate vitamin D
    - Positive parenting
    - Exercise
    - Smoking assessment
    - Alcohol use assessment
  - Physical
    - Ensure appropriate clothing for cold and sun
  - Screening investigations and plan
    - Cervical cytology**
    - Potentially VDRL test for chlamydia, gonorrhea, syphilis
    - Mammography: for **women 50-75 years**
    - Fecal occult blood: for **individuals >50 years**
    - Osteoporosis screening: for **women >65 years**
    - Refer if found to be HIV+ or Hep B+
  - Immunizations
    - HPV: for **females 9-25 years**
    - Varicella: if found to be non-immune
    - Hep B: if found to be non-immune

- **Later visits (3-6mo):** continue with psychosocial, education, physical, and screening considerations from third visit, as well as immunizations indicated in third visit

*****Awareness and alertness of symptoms and signs is recommended over screening for PTSD, depression, intimate partner violence, and social isolation of pregnant women; with some caveats

- PTSD: Potential harm in pushing for disclosure outweighs the benefits. 40% of refugees from countries under war or social unrest experience traumatic events, however most will recover on their own once safe
- Depression: Rates are similar to the general population. If there is access to an integrated system to provide follow up treatment, screening should then take place
- Intimate partner violence: CMAJ guidelines 2011 did not recommend screening, however a more recent review from 2018 has recommend potentially screening all reproductive age women (though without a focus on refugees specifically)

**Counselling surrounding contraception should be done with the patient alone. The patient should be able to request a physician of their preferred gender, especially for the Pap test
***Vision and dental care are partially covered by the IFHP: one emergency oral exam per 6 months along with treatment for caries, trauma, and dental pain, and one eye exam per year

Common Infections, Initial Screening Tests, and Treatments

- **Varicella**
  - High prevalence in tropical countries and older mean age of infection means screening
    and vaccination is appropriate for all ages
  - **Enzyme immunoassay** is adequate for screening despite sensitivity only picking up antibody levels following infection (not vaccination), as specificity is good and many areas don't have childhood vaccination programs.

- **HIV**
  - Stigma and HIV prevalence puts individuals from countries with HIV burden >1% at high risk of infection without access to HIV services
  - Labs generally use two step testing with **ELISA** to detect HIV-1 and HIV-2
  - For information on the treatment of HIV, see chapter on HIV and AIDs

- **Tuberculosis**
  - High incidence of TB in various countries increases likelihood of latent TB infection
  - **Mantoux tuberculin skin test** recommended
  - **CXR** should be carried out if result is positive to rule out active TB
  - Latent TB treatment
    - Rifamycn-based regimen, such as
      - Rifampin daily, 4 months
      - Isoniazid + rifampin daily, 3 months
      - Isoniazid + rifapentine weekly, 3 months (healthy patients ≥2years old)
    - OR Isoniazid monotherapy, daily, 6 months
  - Active TB treatment
    - Intensive phase: isoniazid + rifampin + ethambutol + pyrazinamide, 2 months
    - Continuation phase: isoniazid + rifampin, ≥4 months

- **Hepatitis B**
  - High prevalence of undetected and untreated chronic hep B infection in this population may result in higher mortality from chronic viral hepatitis and hepatocellular carcinoma
  - **Serology** for hepatitis B surface antigen, the antibody to hepatitis B surface antigen, and the antibody to hepatitis B core antigen
  - Vaccination is recommended
  - Chronic hepatitis B treatment
    - Initiate therapy in treatment-naïve individuals with

                - Nucleoside/tide analogue (tenofovir or entecavir preferred), generally ≥4-5 years and potentially indefinite
                    - Entecavir preferred in decompensated cirrhosis
                - OR pegylated interferon (in the absence of cirrhosis)
            - Monitor for response and medication toxicity

- **Hepatitis C**
    - Increased proportion of individuals have chronic hepatitis C, frequently obtained through unsafe medical injections or procedures in their country of origin
    - Increased likelihood of concurrent infection with hepatitis B or HIV
    - Screening tests are **generally third generation serological enzyme immunoassays** for anti-hepatitis C antibodies
    - Positive result on screening should be followed up by a **nucleic acid test** for hepatitis C RNA to confirm circulating virus
    - Chronic hepatitis C treatment
        - Direct-acting antiviral regimen, chosen based on HCV genotype and the presence or absence of cirrhosis
        - Pegylated interferon-alpha is no longer recommended due to efficacy, safety, and tolerability of direct-acting antivirals

- **Strongyloidiasis and Schistosomiasis**
    - High disease burden in migrant populations from Southeast Asia (strongyloidiasis) and Africa (both)
    - Stool ova and parasite is the only way to obtain confirmation, however it has poor sensitivity
    - **Serology** is recommended due to higher sensitivity
    - Strongyloidiasis treatment
        - Ivermectin, one- or two-dose regimen
            - Four-dose regimen if immunocompromised
        - In severe disease, Isoniazid + empiric antibiotics with activity against gram negative bacteria, ≥2 weeks until symptom resolution and 2 weeks of negative daily stool examination
    - Schistosomiasis treatment
        - Praziquantel, single dose

- **Malaria**
    - Routine screening is not recommended, but be aware of symptoms such as fever in individuals who have lived or travelled through endemic areas
    - Perform **rapid diagnostic test** and **thick and thin malaria smears** if suspected
    - Uncomplicated falciparum malaria treatment
        - Atovaquone-proguanil
        - OR quinine + either doxycycline (preferred), tetracycline, or clindamycin

Additional Resources

This section contains resources for providing care for refugee and undocumented patients, as well as a module on global health specific to the elderly population.

Elderly Global Health

- Refugee and Elderly Global Health learning module from the Canadian Collaboration on
  Immigrant and Refugee Health from the University of Ottawa:
  http://ccirhken.ca/e-learning/

Screening for new immigrant and refugee patients

- Canadian Collaboration for Immigrant and Refugee Health screening checklists based on where the patient is from: http://ccirhken.ca/ccirh_main/sample-page/page3-2/
- Evidence-based guidelines for immigrant and refugee health - https://www.cmaj.ca/content/183/12/E824
- More general guidelines/resources - https://refugeportal.wordpress.com/

Other Resources

- Inner city health handbook created by MacHealth DNA

2SLGBTQ+ Health

This chapter explores several health topics as they relate to populations in the 2SLGBTQ+ community.

Glossary

AFAB (adj.) - assigned female at birth

AMAB (adj.) - assigned male at birth

Binding (v.) - (chest binding); use of tight clothing, bandages, or compression garments to visibly flatten the chest

Bottom surgery (n.) - gender-affirming surgery involving transitioning of the genitalia (i.e. vaginoplasty, phalloplasty)

FTM (adj.) - female-to-male

Gaffe (n.) - an elastic garment worn to flatten and hide the genitalia

HRT (n.) - (hormone replacement therapy); part of medical transitioning

MTF (adj.) - male-to-female

Packing (v.) - use of a non-flesh penis/prosthesis to give the appearance of a penis under clothing

Padding (v.) - the use of undergarments or other materials to give the appearance of breasts, hips, buttocks

Top surgery (n.) - gender-affirming surgery involving chest tissue removal/reduction or augmentation

Transgender (adj.) - (trans); a trans person is someone whose gender identity is different from the gender associated with their birth-assigned sex; also an umbrella term to describe folks with gender identities that don't fall into the gender binary

Tucking (v.) - pulling the penis backwards between the legs while pushing the testicles up into the pelvis; or, flattening of the genitalia against the perineum/buttocks using tape, tight undergarments, etc.

Glossary [Internet]. Rainbow Health Ontario. 2020. Available from: https://www.rainbowhealthontario.ca/news-publications/glossary/

2SLGBTQ+ Family Planning

Overview of Family Planning

- People may access fertility services for a variety of reasons; make sure to take a thorough and judgement-free history to understand desired outcome, hopes and expectations
- Remember to use inclusive language - not only female patients will carry a child
- Patience is key - family planning can be a very daunting and expensive process

Family Planning Options

- Adoption and foster parenting
- Assisted reproduction: donor insemination and IVF
- Surrogacy

IVF and OHIP

- OHIP can help cover partial fertility treatments regardless of gender, sexual orientation and financial means. See table below for services covered by OHIP

TYPE	DESCRIPTION	ADDITIONAL ELIGIBILITY	LIMITS ON COVERAGE
IVF	Manually fertilizing eggs with sperm in vitro and then transferring embryo to uterus	Under the age of 43	One treatment cycle/patient Includes 1-time transfer of viable embryos
Artificial Insemination	Transferring sperm into the vagina or cervix	None	No limit
Intrauterine insemination	Injecting sperm directly into uterus	None	No limit

- OHIP will not cover any fertility drugs required ($5000/IVF cycle; $1000/AI cycle) or storage of sperm, eggs and embryos.
- There may be a waitlist for clinics that are supported by government funding. Provided is the link to clinics that accept OHIP for fertility services (https://health.gov.on.ca/en/public/programs/ivf/pub_clinics.aspx)

Fertility Preservation for Transgender Patients

- Prior to transition, all transgender patients should be counselled on the impact it will have on their fertility and options for fertility preservation
- Fertility preservation options generally include sperm, oocyte, embryo, ovarian tissue or testicular tissue cryopreservation
    - For transgender women the most successful option is cryopreservation of sperm prior to initiation of hormone therapy
    - For transgender men the most successful option is cryopreservation of oocytes or embryos
    - For individuals who have not undergone natal puberty it is not currently possible to preserve gametes
- Reproduction in transgender patients who have started their transition but still have their gonads usually requires discontinuation of exogenous hormones
    - There is no good evidence about the timeline of return to fertility and pregnancy success rate. In some patients the loss of fertility will be permanent.
    - Testosterone is a known teratogen that is contraindicated in pregnancy. No good evidence on how long after stopping testosterone treatments is suitable for safe pregnancy.
    - It is important to note that infertility caused by hormone therapy is not absolute. If transgender individuals retain their gonads and engage in sexual activities that could lead to pregnancy, they should be counselled on the importance of contraception.

MSM Health

The Disproportionate Impact of STIs on MSM

- MSM are at greater risk of acquiring STIs such as:
    - HIV
    - HPV - increased risk of anal papilloma
    - Hepatitis B and C
    - Syphilis
    - Gonorrhea
    - Chlamydia

HIV infection risk

- Men who have sex with men (MSM) are a population of people who are at high risk of acquiring an HIV infection
    - Anal sex, in particular, is the sexual activity most associated with HIV
- Epidemiology
    - MSM represent more than half of all HIV cases in Canada, and just under half of the new HIV cases (2018)
    - Risk is thought to be ~130x higher in MSM than in other men
- For more information about HIV and its diagnosis and management, see the chapter on *HIV Infection*

STI Testing for MSM

- The CDC recommends yearly testing for STIs in MSM:
    - HIV
    - Syphilis
    - Hepatitis B
    - Hepatitis C (with known risk)
    - Gonorrhea of the rectum, penis, and/or throat (depending on sexual activity in the past year)

Immunizations for MSM

- The CDC recommends the following vaccines for MSM:
    - Hepatitis A
    - Hepatitis B
    - HPV (up to age 26)

Anal Paps for MSM/trans women

- Can be q1 year for anyone who is high risk (e.g. HIV+ and engaging in receptive anal sex)
    - Anal cytology can reveal dysplasia, for which the gold standard for diagnosis and treatment is high resolution anoscopy (HRA)
        - Access to HRA might be limited in certain regions
        - Ensure there is a local colorectal surgeon who can F/U on results
- Otherwise, assessing risk for anal cancer, sexual practices, and other considerations can be incorporated into patient visits on a case-by-case basis

Other clinical considerations for MSM

- MSM have an increased risk of depression, anxiety, and mood disorders compared to heterosexual men
    - Gay men are 3x more likely to report depression
- MSM have an increased risk of substance use compared to heterosexual men
    - E.g. meth use is 10x higher in MSM than in the general population
- MSM experience higher rates of lifetime suicidality than heterosexual men
    - In 2007, suicide surpassed HIV as the leading cause of death in gay and bisexual men

Safer sex practices

- Protected sex using barrier methods (i.e. condom, dental dam)
- Washing sex toys with soap and water between each use
- Use of lubrication to reduce chance of injury or infection
- Mutual disclosure of STI history with sexual partner(s)
- Use of PrEP for HIV prevention

Helpful resources

- Goodhead.ca: An MSM Mental Health Resource (Ontario)
    - https://goodhead.ca/en/
- Rainbow Health Ontario: Resource Library
    - https://www.rainbowhealthontario.ca/resource-library/topic/msm/
- Canadian AIDS Society's archives for MSM
    - https://www.cdnaids.ca/tag/cas-msm/
- Ontario HIV Treatment Network, section on Men who Have Sex with Men
    - https://www.ohtn.on.ca/research-portals/priority-populations/men-who-have-sex-with-men/

WSW Health

Health Outcomes

- Reliable statistics on HIV transmission from WSW are not available. Important to note that many WSW will continue to have sex with men, but may not receive appropriate counselling.
- Rates of mental illness including substance use disorders, depression, anxiety, and eating disorders are higher among WSW than their heterosexual peers.
- A 2010 survey of intimate partner and sexual violence reported that the lifetime prevalence of rape, physical violence or stalking by an intimate partner was higher for WSW and WSWM than WSM.

STIs

- STIs can be transmitted via sharing sex toys, menstrual blood, mucosal contact, vaginal fluids and skin-to-skin contact
- HPV, HIV, Chlamydia, Gonorrhea and Trichomonas can all be transmitted between WSW
- Despite STI risk, many WSW are not adequately counselled about safer sex practice, prevention options (i.e. HPV immunization) and screening programs (i.e. pap smear).

Safe Sex Practices

- Protected sex using barrier methods (i.e. condom, gloves, dental dam)
- Use condoms on sex toys. Replace condom each time a new person uses sex toys
- Use gloves and lubricant to reduce chance of injury
- Mutual disclosure of STI history with partner(s)

Trans Health

Conducting Physical Exams

Overview

- It is important to conduct physical exams and screening for the anatomy that is present. For this reason, a sensitive and comprehensive history detailing individual changes may be helpful.
- Only ever perform a physical exam on the body system/part that is relevant for the appointment. Explain reasoning for each physical exam maneuver.

Pap Smears for Transgender Men

- Transgender men access cervical cancer screening services less frequently than cisgender women, but if they retain their cervix, they are not at reduced risk for cervical cancer.
- This can often be an uncomfortable/traumatic experience for patients. Here are few steps to make them more comfortable:
    1. **Make sure patients understand the procedure:** book multiple appointments to discuss what will happen, walk through the procedure step by step, provide a mirror so patients can view the exam, show pictures of speculum and pap tests.
    2. **Allow for additional support:** provide the option for patient to bring support person into the room
    3. **Minimize exposure:** interview patients before asking them to put on a gown, only ask them to change from the waist down.
    4. **Use vocabulary patients are comfortable with:** ask patients what words they use for their body parts (e.g. front hole)
    5. **Consent:** Remind patients the exam can be stopped at any time if they ask
    6. **Comfort:** Testosterone may lead to vaginal dryness - lube and warm water can assist in speculum insertion, vaginal estrogens 1-2 weeks prior to exam may decrease vaginal atrophy.
    7. **Sending lab sample:** sample from pap smear or pelvic exam labelled male be thrown out or have the incorrect test run on it, clearly label sample from transgender man and if they are taking testosterone or not to avoid needing to repeat exam.

Gender-Affirming Care

Hormone Replacement Therapy

Hormonal Agents

Feminizing	Masculinizing
• **Anti-androgens** - goal is androgen suppression; this is not required following orchiectomy • **Estrogen** - typically in oral format; initiates feminization • **Progestins** - controversial due to minimal evidence of benefit and high risk of side effects • Risks: weight gain, infertility, HTN, T2DM, CVD, nipple discharge, stroke, increased risk of breast cancer compared to cisgender men, hyperlipidemia, DVT, PE • Contraindications: unstable ischemic CVD, estrogen-dependent cancer, end-stage chronic liver disease, hypersensitivity to formulation • Dosing: Begin at low dose and titrate upwards. Should see patients for follow up at 3, 6, and 12 months and then on an annual basis, but some providers will choose to see patients monthly until full dosage is reached. Investigations to be conducted include: CBC, ALT, Cr, lytes, HbA1c, lipid profile, total testosterone, estradiol	• **Testosterone** - IM and transdermal preparations; initiates masculinization • Risks: weight gain, acne, sleep apnea, HTN, T2DM, DVT, PE, pelvic pain, clitoral discomfort, vaginal atrophy, infertility, polycythemia • Contraindications: pregnancy or breastfeeding, active sex hormone cancer, unstable ischemic CVD, hypersensitivity to one of the components of the formulation • Dosing: Begin at low dose and titrate upwards. Should see patients for follow up at 3, 6, and 12 months and then on an annual basis, but some providers will choose to see patients monthly until full dosage is reached. Investigations to be conducted include: CBC, ALT, HbA1c, lipid profile, total testosterone. Prior to the first dose, a pregnancy test must be conducted.

What to Expect: Feminizing Therapy

Tissue/System Impacted	Description of Change	Reversibility	Time of Onset	Time to Max Effect
Skin	Softer Decreased acne	YES	6-12 Months	>3 years
Body and Facial	Thinned/slowed	YES	1-3 Months	>3 years

Hair	growth			
MSK	Decreased muscle mass/strength	YES	3-6 Months	1-2 years
Breast Tissue	Growth to tanner stage 2-3	NO	3-6 Months	1-2 Years
Reproductive System	Decreased testicular volume Decreased libido Decreased spontaneous erections	Variable	3-6 Months 1-3 Months 1-3 Months	2-3 Years 3-6 Months 3-6 Months
Body Fat	Redistribution from abdomen and mid section	YES	3-6 Months	2-3 Years

What to Expect: Masculinizing Therapy

Tissue/System Impacted	Description of Change	Reversibility	Time of Onset	Time to Max Effect
Vocal Changes	Deepened Voice	NO	6-12 Months	1-2 years
Body and Facial Hair	Increased/thicker growth	NO	3-6 Months	4-5 years
MSK	Increased muscle mass/strength	YES	6-12 Months	2-5 years
Reproductive System	Cessation of Menses Clitoral enlargement Vaginal Atrophy	YES NO YES	1-6 Months 3-6 Months 1-3 Months	N/A 1-2 Years 3-6 Months
Body Fat	Redistribution	YES	1-6 Months	2-5 Years

	from thigh/hip/buttock			

Physical Alteration Practices & Safety

- **Liposuction or lipofilling** (to achieve desired body contour)
  - Watch for complications like infections and necrosis
  - Not publicly funded
- **Chest binding**
  - Consider use of dedicated binders/garments versus the use of wraps and other non-commercial materials
    - The right size should be comfortable (no difficulty breathing, skin irritation, chafing, etc.)
  - Ask patients about binding practices and monitor for any negative symptoms (e.g. back pain, overheating, rashes)
    - Suggest use of breathable materials to minimize rashes and sores
  - Counsel patient on potential side effect of reducing skin elasticity - which can impact top surgery outcomes
- **Packing**
  - Watch for skin irritation or allergic reactions to the material of the prosthesis
- **Genital tucking**
  - Advise self-checking for sores and rashes, and working gently to avoid sensitive tissue tears
  - Encourage taking breaks or tucking for shorter periods of time for those new to tucking
  - Encourage use of hypoallergenic tapes and materials
  - Watch for symptoms like dysuria, tingling, pain, etc.
  - Consider potential impact on fertility and discuss with patient appropriately

Gender-Affirming Surgery

- **Breast augmentation**
  - MTF individuals
  - A form of top surgery
  - Publicly funded by OHIP for MTF trans folks who have been on estrogen for 12 months with zero breast growth
    - clinical consideration: measuring chest circumference at visits
- **Masculinizing chest surgery**
  - FTM individuals
  - A form of top surgery
  - Includes: chest contouring procedures, mastectomy (removal of breast tissue)
- **Genital surgery**
  - A form of bottom surgery
  - Can include:
    - *Hysterectomy* - removal of uterus
    - *Salpingo-oophorectomy* - removal of ovaries/fallopian tubes

        - *Vaginectomy* - removal of vaginal mucosa and closure of vaginal canal
        - *Orchiectomy* - removal of the testes
        - *Metoidioplasty* - creation of microphallus from hormonally enlarged clitoris
        - *Scrotoplasty* - creation of scrotum using skin flaps or labia majora, typically with or following metoidioplasty or phalloplasty
        - *Phalloplasty* - creation of a penis using pedicled or free vascularized skin flap
        - *Urethroplasty* - repair of urethra
        - *Testicular prosthesis/erection prosthesis* - placed after surgery and recovery
    - Monitor and ask about infections, pain, or other symptoms post-surgery
    - **Indications and requirements for gender-affirming surgeries:**
        - Persistent gender dysphoria
        - Capacity to consent
        - Reasonable well-controlled medical and mental health conditions
        - Being age of majority
        - Must undergo a surgical readiness assessment
        - 12 months of continuous HRT (required before most genital surgeries)
- **Transition-related surgeries not OHIP-covered (cosmetic)**
    - Chondrolaryngoplasty/tracheal shave - Adam's apple reduction surgery
    - Breast augmentation
    - Facial feminization
    - Buttock re-contouring with liposuction and fat grafting

Considerations for Clinical Practice

- Take a detailed social history:
    - **Recreational drugs** - Trans Ontarians are more likely to use cocaine and amphetamines than non-trans counterparts
    - **Alcohol** - Estimated prevalence of heavy episodic drinking is 1.5x higher in trans Ontarians than their non-trans counterparts
    - **Chronic disease and low income -** compared to cisgender controls, trans people are more likely to live in lower income neighbourhoods and experience chronic physical and mental health conditions (COPD, asthma, diabetes)
    - **Suicide -** A 2015 study showed that among trans Ontarians, 35.1% seriously considered, and 11.2% attempted, suicide in the past year
- Anal Paps
    - See section under MSM Health in this chapter

Safer Sex for Trans Folks

- Lubrication - to help reduce friction and tears
    - Especially important for trans women with vaginas that might be less elastic and more delicate especially soon after bottom surgery
    - Trans vaginas don't self-lubricate as well
- Using dilators - for trans women with vaginas, penetration can be painful and causing tearing
    - Using dilators can help with pain and tearing, especially after recent bottom surgery

Health Outcomes and Statistics

- Outlook Study
    - Over 70% of trans folks in Waterloo region feel unsafe in hospitals, emergency rooms, medical offices, and urgent care centers
    - 76% of trans people in Waterloo have had to educate at least 4 health care providers about gender identity
    - Find the infographic at the Rainbow Community Council website:
        - https://yourwrrc.ca/rcc/wp-content/uploads/2019/05/Trans-Infosheet-v.06-SMALL.pdf

Helpful Resources

- Articles on binding, packing, and tucking from Trans Care BC:
    - http://www.phsa.ca/transcarebc/care-support/transitioning/bind-pack-tuck-pad
- Rainbow Health Ontario: Resource Library
    - https://www.rainbowhealthontario.ca/resource-library/topic/msm/
- Trans Lifeline (1-877-330-6366). Their schedule is available at:
    - http://hotline.translifeline.org
- Infographic from the Youth Gender Action Project by Central Toronto Youth Services:
    - http://ctys.org/wp-content/uploads/YGAP_Health-1.pdf

Healthcare Considerations for Sex Workers

Sex workers face an extremely high burden of unmet healthcare needs due to the criminalization and policing of sex work, pervasive stigma and discrimination against sex workers in the healthcare system, and lack of culturally competent care. It is incumbent on all healthcare professionals to understand these healthcare barriers and work towards dismantling them.

Healthcare Considerations for Sex Workers

Why do People Choose to Engage in Sex Work?

Individuals make the decision to engage in sex work based on the options available to them. While some people engage in sex work for survival (known as "survival sex work"), that is not the case for all sex workers. Some engage in sex work to resist certain forms of oppression (e.g. economic exploitation, ableism) or to pursue personal goals. Many feel that sex work gives them the freedom to set their own schedule, earn a higher wage, and run their own business.

Avoiding the Savior Complex

Despite the agency many feel in engaging in sex work, healthcare providers often believe sex workers need to be "saved" from their work. This is known as the "savior complex", which can happen in any context where an individual has more privilege than the community they are trying to serve. Given this power imbalance, it is crucial to mindfully listen to your patient in order to understand what they want for themselves.

Migrant Sex Workers

Migrant sex workers are an especially vulnerable subpopulation, as exposure of their work status or the involuntary involvement of law enforcement could result in deportation and compromise immigration status. Migrant sex workers include those who either:
1) do not have work permits, such as visitors, or
2) those with open work permits, such as international students, refugee claimants, and those under sponsorship, who are not allowed to be employed in the sex industry.

Definition of Sex Work

What it is:
An umbrella term for the provision of sexual services or performances by a person for a client, who provides some form of compensation.

"Sex work" can encompass the work of prostitutes, escorts, strippers, porn actors, sex phone operators, etc., but not all people who participate in these forms of work identify as sex workers (partly due to stigma and criminalization).

We like the term "sex work" because it emphasizes the human rights and labour rights of sex workers. It is also less pejorative and less gendered than many other terms.

What it is not:
Sex work should not be conflated with sex trafficking. Sex trafficking is a human rights violation where individuals are forced, coerced, or deceived into engaging in sexual acts. On the other hand, sex work is a consensual transaction between adults.

Sex work is not inherently exploitative; this assumption diminishes the agency of sex workers. It also limits the understanding of the diversity of sex workers' lives and the complexity of their needs and concerns.

The Health Impacts of Laws Governing Sex Work

Sex work is regulated by **Bill C-36, Protection of Communities and Exploited Persons Act (PCEPA)**, which outlaws "common bawdy-houses", prohibits "procuring" prostitution or "living on the avails" of prostitution, and "communicating for the purposes of prostitution".

This means that while prostitution and sex work are legal in theory, many aspects of sex work are illegal. This enables heavy policing of sex work, leading to high rates of police violence, pimping, and arrests; it also generally threatens the agency, safety, and well-being of sex workers.

For example, the "bawdy house" laws prevent sex workers from working in safe indoor locations because virtually any place where services are communicated or where sex work regularly occurs can be labeled a bawdy house.

The law prohibiting living off the "avails of prostitution" implicates the people in sex workers' personal and professional lives, such as dependents, roommates, and family and friends, making it challenging for sex workers to disclose their work status to healthcare professionals.

By outlawing "communication for the purposes of prostitution", this bill also limits the ability of sex workers to screen or safety negotiate with their clients, which puts sex workers at greater risk of violence and other negative health outcomes outlined below.

Vulnerability to Violence

As sex workers operate in a criminalized work environment, they are especially vulnerable to police violence, which includes staged arrests, sexual harassment, and sexual assault. The criminalization of sex work, as mentioned above, also makes it difficult to report incidents of violence or seek help. Sex workers are also more likely to be victim-blamed by and receive less empathy from medical professionals than the general population.

Research has also shown that sex workers who are homeless, who've been previously arrested for sex work, who are migrant workers, who use drugs, or who are street-based are at highest risk of experiencing violence.

Barriers to Healthcare

"We need doctors to treat us like human beings. When we go to access social services and answer genuinely [about our work], we are judged. You can see the attitude change when you disclose [your involvement in sex work]."

The facts:

Sex workers report that stigma against sex work is the greatest barrier to accessing care.

The percentage of unmet health care needs for sex workers is nearly three times higher than for the general population.

44% of sex workers do not have access to a regular doctor, compared to the Ontario average of 7%*

The greatest barrier to sex workers' health is the stigma and discrimination they often face from healthcare providers. Many sex workers have reported experiences such as disrespectful and abusive language, public humiliation, physical separation from other patients, inferior service, and blame when reporting sexual assault. Over a quarter of respondents in one study reported they were unable to access acceptable healthcare due to feeling disrespected by healthcare providers.

As such, many sex workers distrust public safety and healthcare systems, as these very systems have failed to keep them or their colleagues safe and have often perpetuated further harm. Consequently, sex workers often report managing health issues on their own, leading to delayed treatment and increased use of acute emergency services.

Almost 40% of sex workers surveyed in a study reported that they almost never disclose their occupation to healthcare providers due to fear of mistreatment or confidentiality concerns. However, lack of disclosure impedes the initiation of necessary preventative care, delays connection to social services, and results in overlooked mental health needs.

*based on a survey of sex workers in Toronto

Addressing the Disparities in Health Outcomes

The rate of HIV in sex workers is 6 times higher than in the general population, and there is an increasing prevalence of syphillis amongst sex workers*

One of the major barriers to healthcare for sex workers is the criminalization of their work, which forces workers into dangerous and isolated settings to avoid police harassment. Having to operate covertly has prevented sex workers from adequately appraising their clients to establish safe sex conditions for the transaction. Consequently, this has led to higher rates of STIs among sex workers, especially for HIV and syphillis.

¾ of Canadian sex workers meet criteria for PTSD

Sex workers are at greater risk of physical and sexual violence than the general population. Studies generally show that sex workers have a higher rate of diagnosed anxiety (33.7 %) and major depression (24.4%) than the general population. Given these mental health needs, appropriate screening for mental health concerns should be undertaken, along with referrals to mental health care and peer support services.

Approximately 56-57% of Canadian sex workers use intravenous drugs

It is important to note that the use of drugs may be necessary for some to engage in their work, which may be due to personal preference or due to clients' expectations. As such, appropriate harm reduction strategies for IV drug use should be discussed with patients.

**based on data collected in Vancouver, as Canada does not currently track data on the intersection of HIV and sex work*

The Issue of Confidentiality

Many sex workers decline to disclose their occupational status due to fear of arrest. Many also fear having their occupation labeled in their medical records; some worry about medical records being subpoenaed for custody cases, other legal proceedings, or even post-secondary applications. There is also concern that having a record of their work status could also result in discriminatory care from other healthcare providers in the future. As such, it is important to address these concerns with patients and offer the option of not mentioning sex work in a patient's medical record if requested.

Culturally Competent Care

It is critical to consider the individual, community, societal, and policy factors that sex workers face when seeking treatment. As a community that faces vulnerability to violence, stigmatization, and criminalization, access to culturally competent healthcare is vital. Across several studies, sex workers consistently request non-judgemental, caring, respectful, and compassionate healthcare providers who take the time to listen to their needs and concerns.

Recommendations for culturally competent care:

Seek consultation for any potential internal biases against sex work/sex workers

Employ trauma-informed and non-judgemental care

Understand your patient's needs and barriers to health: use a harm-reduction approach to meet these needs

Approach conversations about healthcare concerns in a way that centers patients' agency

Involving peer workers to help sex workers access services has been shown to lead to improved health outcomes

Resources for Patients

Sex-worker-led organizations are best positioned to provide supports and services that are safe, relevant, and accessible to other sex workers. Familiarize yourself with the local grassroots organizations that are doing this work.

It can also be helpful to alert patients to local bad date lists (a list of dangerous clients), resources for safe sex and safe injection supplies, and resources where sex workers can find community and social support.

Healthcare for Incarcerated and Detained Patients

This chapter explores harm reduction and trauma-informed approaches to caring for patients who are in prison or detention.

Preface

People who are incarcerated or detained are in a vulnerable position with respect to health care: they do not control the choice to visit an ER or physician; they depend on the institution to provide for basic needs (1) and to support their access to desired/indicated care.

There are 2 types of correctional facilities in Canada: 1. **Federal** correctional facilities *(for those with sentences of 2+ years)* and 2. **Provincial/territorial** correctional facilities *(for those detained prior to judgment/sentencing, and those with sentences <2 years)*. It is a legal obligation to provide health care for people who are detained and incarcerated (2).

Epidemiology

From 2020 to 2021, there were over 140 000 total custodial admissions across Canada (3). In any given day, there are approximately 40 000 people in correctional facilities (3).

For Indigenous peoples, the ongoing **intergenerational impact of colonialism and systemic racism** have led to disproportionate overincarceration (4). Indigenous women lose 6 to 9 times more years of life compared to non-Indigenous women; Indigenous men lose 4 to 6 times more years of life compared to non-Indigenous men (5). "Yet, even these estimates of years of life lost to incarceration do not account for the years of life lost resulting from health effects of incarceration" (4). There is likewise an **overrepresentation** of Black individuals in the federal correctional system. From 2020 to 2021, Black people constituted 4% of Canada's overall population but accounted for 10% of admissions to custody (6).

Incarceration is associated with the following:

- **Decreased life expectancy** by 2 years for every 1 year spent incarcerated (7)
- **Increased risk of death** after release from incarceration compared to average risk of death in the community; this is largely attributable to overdose and suicide (8)
- **Negative effects on social determinants of health** including, but not limited to, housing status and career opportunities (9)
- **Increased rates of recidivism** and/or future involvement in the criminal justice system, leading to a cycle of vulnerability (10)

Rights of the patient

• • •

Confidentiality and privacy with respect to personal health information should be respected, even if patients are detained or incarcerated
Non-health care correctional staff may be asked to leave the room. If they must stay, advocate for as much privacy for your patient as possible and document who was present during the encounter.

Only report to law enforcement when you have a clear duty to report; patient health information may only be reported with the patient's consent or if required by law.*

Court orders: includes subpoena/summons, which are orders to appear in court; records are to be released to court via a sealed envelope at the time and location indicated. This does not include providing information to the police.

Search warrant: enables police authority to search for information; must be signed by a Justice of the Peace. Health care staff should ask to inspect the warrant Record the officer's name and badge number and photocopy the search warrant. Only provide specific information listed. (14)

There are limits to confidentiality, including **duty to report** (15):

- Child in need of protection to child welfare authorities
- Patient with condition impairing driving ability to motor vehicle legislation
- Patient with certain communicable diseases to the medical offer of health
- This is a non-exhaustive list; legislation for each province and territory should be consulted.

Conditions

Imprisonment is associated with a high burden of illness. Evidence suggests a greater prevalence of acute and chronic conditions compared to the general population, including mood/anxiety disorders, blood-borne and sexually transmitted infections, and cardiovascular diseases (11).

In addition, there is a higher prevalence of mental health conditions and substance use disorders in prison medicine. Even in the context of accessible mental health care, mental health needs may go undetected or untreated in the setting of correctional facilities (2).

The following table summarizes prevalent conditions that are more common in people who are incarcerated.

Conditions	Examples[11]
Communicable diseases	• Hepatitis C • HIV • Tuberculosis
Non-communicable diseases	• Hearing impairment • Heart disease • Hypertension • Obesity
Mental health conditions	• Anxiety • Depression (MDD) • Obsessive-compulsive disorder (OCD) • Psychosis • Substance use disorders • Suicidal ideation/suicidality

Trauma-informed care

Patients may have experienced substantial trauma prior to or during detainment or incarceration (12). As such, a trauma-informed approach should inform your care, including elements such as:

- Recognizing the pervasiveness of trauma and the role of institutions in perpetuating trauma
- Building trust and transparency in the patient-physician relationship; avoiding re-traumatization
- Addressing power dynamics and empowering patients to make their healthcare decisions

Caring for your patients (13)

- Acknowledge that patients may be apprehensive about receiving care and establishing a therapeutic relationship, as they may perceive physicians as authority figures within an oppressive system.
- Always speak directly to the patient, even if they are accompanied by security staff
- Be clear about the role of confidentiality and its potential limits within the patient encounter.
- Ultimately, it is the health care professional's obligation to care for the patient with respect and to meet professional standards of care.

Please refer to the links in the additional resources section below for further information on healthcare in carceral spaces, in addition to ways to advocate for patients who are detained.

Additional resources

- Caring for people who are detained
- CMAJ | Prison medicine

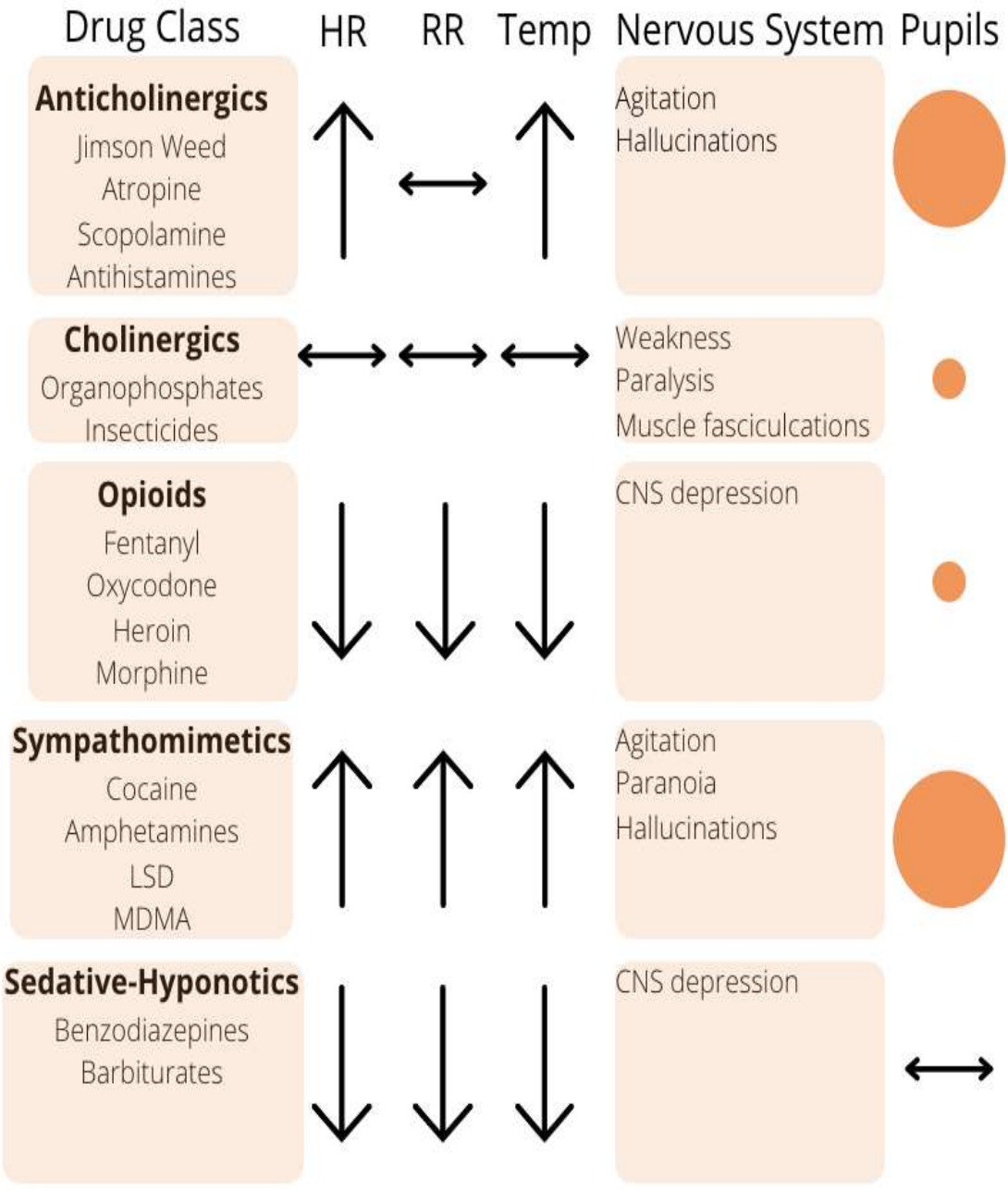
OTHER SOCIAL MEDICINE TOPICS

ADDICTIONS MEDICINE

Opioid Use Disorder

- Signs and Symptoms of Opioid Overdose
- Acute Management of Opioid Overdose
- Guides to Prescribing Suboxone in an Inpatient Setting
- How to Continue an Outpatient Methadone Rx in Hospital

Toxidromes



Note: it is important to recognize that a person may present after using more than one substance and, as a result, the toxidrome may be mixed.

Acute Management of Opioid Overdose

1. **Identify the Overdose** (refer to toxidromes above)
2. **Attempt to Rouse the Patient**
    - Verbally encourage the person to take breaths. If they do not respond, stimulate physically.
3. **Airway Management**
    - After ensuring the airway is clear, provide supplemental oxygen via non-rebreather mask at 10L/min to assist respirations. Can also use bag valve mask set-up.
4. **Naloxone Administration**
    - Administer naloxone 0.4mg IV/IM.
    - Titrate by 0.4mg-1mg IV/IM naloxone every 2-3 minutes until RR > 12.
5. **Observation**
    - The patient must be monitored for at least 6 hours after the last dose of naloxone and at least 24 hours after the initial overdose. Vital signs must have returned to baseline and GCS must be normal.

IMPORTANT CONSIDERATIONS:

1. The onset of naloxone is within 2 minutes and the duration of action is 20-60 minutes. Be prepared to administer multiple doses if necessary.
2. In the absence of opioid withdrawal, there is no maximum safe dose of naloxone.
3. If a clinical effect does not occur after administering 5-10mg of naloxone, reconsider your diagnosis.
4. Naloxone can precipitate acute withdrawal symptoms in patients with physical depends. This presents as hypertension, sweating and agitation. If a patient is in withdrawal, focus on providing comfort care – talk softly, reorient them, dim the lights, etc.
5. The average dose of naloxone required in an opioid overdose is 3mg, but there are some reports of naloxone dosing of 12mg being necessary to treat an opioid overdose.

Guide to prescribing suboxone in an inpatient setting

DEFINITIONS:

Suboxone: a combination of buprenorphine and naloxone at a ratio of 4:1 administered **sublingually or buccally (NOT PO).**

Buprenorphine:

- Partial opioid agonist: produces a lower functional response at the level of the receptor compared to full opioid agonists (ex: heroin) --> limited euphoria, analgesia and respiratory depression.
- High affinity for opioid receptors: effectively displaces other opioids (heroin, morphine) from opioid receptors.

Naloxone:

- Potent opioid antagonist: antagonizes the euphoric effects of buprenorphine if injected intravenously.
- Added to buprenorphine to deter drug misuse (i.e. IV injection). Has no effect when administered properly (i.e. sublingually, buccally).

ASSESSMENT:

1. Obtain substance use history. Can get a brief history while someone is in acute withdrawal and a more fulsome history once withdrawal is managed.
2. Confirm that the patient meets the criteria for opioid use disorder
3. Rule out contraindications:
    a. Allergy

PRESCRIBING:

There are many different ways to prescribe Suboxone (microdosing, macrodosing, etc.). The dosing below follows CAMH guidelines, but be aware that there is a lot of flexibility and practice variability in prescribing Suboxone.

DAY ONE:

1. Discontinue all opioid prescriptions
    - Patients must be in some withdrawal before starting suboxone unless they are more than 5 days off of opioids
        - Requires 12 hours of abstinence for short-acting opioids
        - Requires 24-48 hours of abstinence for long-acting opioids
2. Evaluate the patient's COWS score
    a. If COWS score <12 or no objective signs of withdrawal:
        i. Reassess q2h while awake until COWS >12

b. If COWS score >12 with objective signs of withdrawal:
    i. Administer suboxone 4mg/1mg SL
    ii. Reassess after 2 hours
        1. If withdrawal symptoms present: administer additional doses of suboxone 4mg/1mg SL q2h PRN with a maximum day 1 dose of 12mg/3mg
        2. If withdrawal symptoms have resolved: proceed to day 2

DAY TWO:

1. Administer total daily dose from day 1
2. Titrate based on withdrawal symptoms and side effects

SUBSEQUENT DAYS:

1. Administer day 2 total dose as ongoing dose
2. Increase dose as needed for recurrence of withdrawal, pain or cravings
3. Decrease dose as needed for sedation, insomnia, adverse effects
4. Typical maximum dose is 24mg/6mg SL

MAINTENANCE (post-discharge)

1. Ensure the patient is being discharged to an outpatient provider with good handover.
2. Provide a prescription for their dose to cover for 5-7 days or until they can see an outpatient provider. The prescription will be for daily witnessed dispensed doses.

How to continue outpatient methadone prescriptions in hospital

DEFINITIONS:

Methadone: long-acting full opioid agonist that replaces shorter-acting opioids, like heroin and oxycodone at the level of the receptor.

ASSESSMENT:

1. Obtain a substance use history.
2. Obtain methadone use history:
    a. Who prescribes their methadone and from what pharmacy do they receive the methadone?
    b. Do they receive their methadone by daily witnessed doses or do they have carries?

c. What is their current dose of methadone? How long have they been on that dose? Is the dose currently being titrated?

d. When was the patient's last dose of methadone?

PRESCRIBE:

- If no missed doses of methadone, prescribe the patient's outpatient dose.
- If 1-2 missed doses: do not reduce the dose unless there are concerns about loss of tolerance or adverse events.
- If 3 missed doses: decrease the dose by 50%.
- If 4+ missed doses: decrease the dose to 30mg or less.
- Consider consulting the patient's outpatient methadone prescriber for further instruction.

DISCHARGE:

1. Ensure the patient is being discharged to an outpatient provider with good handover.
2. Provide a prescription for their dose to cover for 5-7 days or until they can see an outpatient provider. Discharge with carries if they had carries prior to admission and there are no concerns for destabilization.

Adjunctive medications for withdrawal

Adjunctive medications for opioid withdrawal can be helpful for safely controlling symptoms and ensuring patient comfort while initiating methadone or suboxone therapy:

- Ondansetron 4mg PO q6h PRN for nausea (be aware of patient's QTc)
- Diphenhydramine 25-50mg PO TID PRN for insomnia, anxiety (be aware of patient's QTc)
- Ibuprofen 400-800mg PO QID PRN for pain
- Acetaminophen 650mg PO q4h PRN for pain
- Loperamide 4mg PO PRN for loose stools
- Clonidine 0.1mg PO q6h PRN for withdrawal symptoms

Harm Reduction

- Definitions
- Guiding Principles
- Harm Reduction
- Naloxone
- Community Resources

DEFINITION

Harm reduction: policies and interventions that aim to reduce the negative consequences associated with certain behaviours, including drug use.

Guiding Principles

Practical Interventions

- Harm reduction emphasizes small, practical steps that people can take to reduce harm.
- **For example:** using sterile, unused equipment for every injection is safer than sharing, lending or borrowing equipment.

Non-Judgment

- Harm reduction providers care for, respect and dignify patients as individuals.
- Providers understand that people make decisions for a reason; health behaviours that are associated with harm also provide some benefit to these individuals and these benefits must be assessed, acknowledged and understood in order to contemplate the balance between harms and benefits.
- **In practice:** harm reduction services are user-friendly and responsive to patient's needs. Providers accept patients' choices. People are not expected or required to stop using drugs.

Autonomy

- Individuals ultimately have the right and power to make their own choices about their health, treatment and medications.
- There are a variety of social and structural barriers that can limit a patient's power and autonomy. As providers, we work to address these barriers so that patients can access the choices they want for themselves.
- **In practice:** shared decision-making and patient-centered care is emphasized.

Accountability Without Termination

- Patients are not abandoned for not achieving their goals
- Patients have the right to make health decisions that have harmful consequences and harm reduction providers can still provide them with support and information to understand the impact of their choices.
- In practice: backwards movement is not penalized.

Harm Reduction Supplies

Alcohol swabs: used to clean the skin around the injection site before injecting

Sterile cookers: container used for preparing, mixing and heating a drug prior to injection

Sterile filters: placed in the cooker after the solution has cooled and used to filter out any binders (chalk, wax) and other particles from the drug solution prior to injecting

Sterile water: mixed with solid and powder drugs, then heated in a cooker to convert drugs into an injectable solution

Tourniquets: used to help raise veins, making them more evident and easier to identify. Much safer than belts, shoelaces or wires, which can make it difficult to inject, cause trauma to skin and blood vessels, and disrupt blood flow.

Vitamin C/ascorbic acid: used to convert insoluble drugs (ex: crack cocaine) into a water-soluble solution.

Straight stems: used for smoking crack cocaine

Bowl pipes: primarily used for smoking crystal meth

Mouth pieces: attached to the end of straight stems and bowl pipes to prevent burns, cuts and to protect lips from cracked stems

Foil: used as a heating surface for drugs that will be vaped or inhaled

Naloxone

- Fast-acting **opioid receptor antagonist** that is **used to treat opioid overdoses**.
- Should be routinely discussed with all patients when prescribing or renewing medication to treat opioid use disorder, all patients at risk of opioid overdose, and all patients with household members or other close contacts at risk for accidental ingestion or opioid overdose.
- **Naloxone kits are free and available at most pharmacies** across the province. They do not require a prescription or an Ontario health card to access.
- Naloxone kits **may contain injectable intramuscular naloxone or nasal spray**.
- Patients must be counselled on how to recognize an opioid overdose (see Chapter on Opioid Use Disorder)
- Instruct patients on **how to respond to an overdose**:
    - Shout the person's name, shake their shoulders, rub your knuckles against their sternum
    - If they are unresponsive, call 9-1-1
    - Give naloxone
        - Injectable kit: inject 1 vial (0.4mg/ml) into their upper arm or upper thigh
        - Nasal spray: lay the person on their back, insert the tip of the spray nozzle into one nostril; press the plunger firmly
    - Give 30 chest compressions and two rescue breaths
    - If no improvement in 2-3 minutes, give another dose of naloxone as above
    - If the person begins breathing on their own, put them in the recovery position and stay until the ambulance arrives in case the overdose symptoms recur
- Patients must be aware that naloxone has a short half-life of 20-90 minutes, and that it's possible for a person to overdose again after initial rescue with naloxone.

Community Resources

The Van Program:

- Delivers new needles and harm reduction supplies to clients
- Also provides limited clinical services once a week including sexual health services (HIV testing, STI screening, Hep C testing) and some first aid services
- Travels anywhere in Hamilton and is available to meet at requested meeting spots – clients are to call or text (905) 317-9966
- Operates every night from 7PM-11PM (except statutory holidays

The AIDS Network – Needle and Syringe Program:

- Provides free information and arm reduction materials necessary to practice safer drug use and safer sex
- Can provide community support referrals, including social services, housing and welfare, and drug treatment centers
- Located at 140 King St E, Suite 101
- Open Monday-Friday, 9AM-5PM

Consumption and Treatment Service

- Provides supervised injection services, as well as sterile injection supplies, education, overdose prevention and intervention, and nursing staff
- Also offers counselling, referral services and harm reduction education and supplies
- Located at Hamilton Urban Core, 71 Rebecca Street
- Open every day – see website for hours (hucchc.com)

Keeping Six:

- Weekly outreach with lunches and harm reduction supplies for folks who are precariously housed and folks who use drugs
- Operates Sundays from 1PM-4PM in the downtown core

National Overdose Response Service Line:

- NORS offers a 24/7 confidential overdose prevention service so that folks can have someone stay on the line with them while they use. If the person becomes unresponsive, the NORS operator can then alert 911 to keep them safe.

- Phone number: 1-888-688-NORS(6677)

Additional Resources

This section includes resources from medical institutions regarding medical treatments for opioid and alcohol use disorders such as medical detoxification, as well as podcasts and videos documenting the lived experiences of people with addictions and resources on harm reduction.

General

- META:PHI Guides https://www.metaphi.ca/guides.html
    - Tools and educational resources supporting clinicians providing care to people with substance use disorders in a variety of settings
- Podcast: "Addiction in Simple Terms," Dr Julian Keats
- Podcast: "On Drugs" https://www.cbc.ca/radio/ondrugs

Medical Detoxification Protocols

- Protocols for detoxification from alcohol, benzodiazepines, barbiturates, and opioids, from the University of Toronto's Psychiatry Hub: http://thehub.utoronto.ca/psychiatry/wp-content/uploads/2014/05/Appendices-for-Substance-Use-Disorders.pdf

Alcohol Use

- Primer on Alcohol Use Disorder from the University of Toronto's Family Medicine Hub (2-page overview): http://thehub.utoronto.ca/family/wp-content/uploads/2016/12/Alcoholism.pdf
- Alcohol Use Disorder Tool from Centre for Effective Practice: http://thehub.utoronto.ca/family/wp-content/uploads/2020/02/20191003-CEP_AUD-rev.12_UPDATED.pdf
- Reference manual for treating alcohol use disorder from British Columbia Centre on Substance Use: https://www.bccsu.ca/wp-content/uploads/2020/03/AUD-Guideline.pdf

Opioid Use

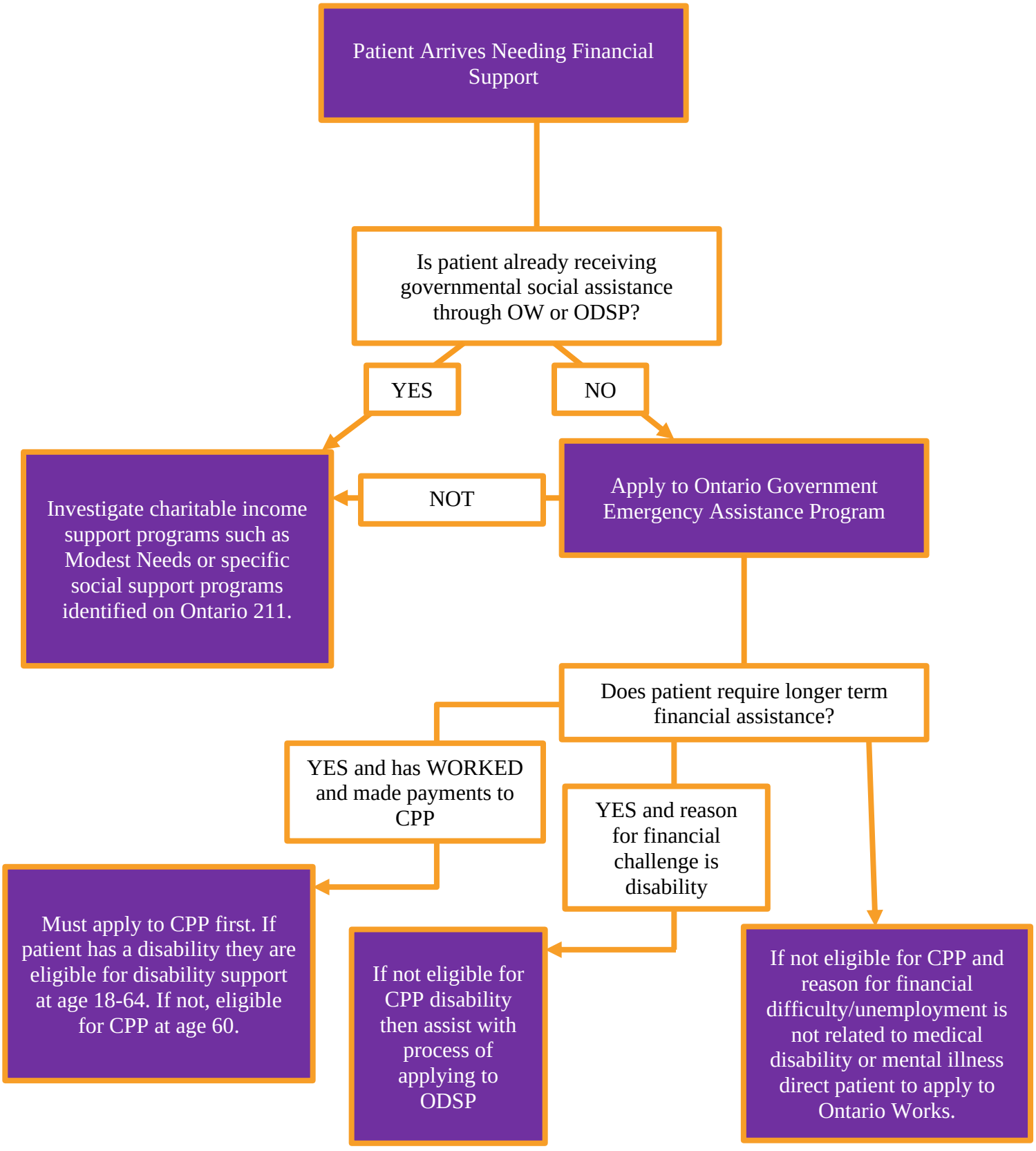
- UBC Faculty of Medicine's Provincial Opioid Addiction Treatment Support Program Provincial Opioid Addiction Treatment Support Program | UBC CPDOnline Course (free full course on diagnosing and treating opioid use disorder): https://ubccpd.ca/course/provincial-opioid-addiction-treatment-support-program
    - Includes 2017 Guideline for the Clinical Management of Opioid Use Disorder
- Canadian Research Initiative in Substance Misuse: National Guideline for the Clinical Management of Opioid Use Disorder https://crism.ca/projects/opioid-guideline/
    - For patients who do not use fentanyl
    - CMAJ synopsis here https://www.cmaj.ca/content/190/9/E247

- Module on responding to overdose in a community setting: http://www.naloxonetraining.com/training

Harm Reduction

- Podcast: "Crackdown" https://crackdownpod.com/
- Hamilton Mutual Aid webinar- mutual aid responses to COVID-19: https://www.youtube.com/watch?v=qLOKSjf92j0&ab_channel=ClaireBodkin

INCOME SUPPORTS FLOWCHART



Ontario Disability Support Program

This chapter will summarize ODSP including its eligibility criteria, a description of how to fill out an ODSP form, and additional benefits for ODSP recipients and their families.

Ontario Disability Support Program (ODSP)

Eligibility

1. Age 18+
2. Resident of Ontario
3. Financial Need
4. Person with a disability that has caused substantial physical or mental impairment on a continuous or recurrent basis over the past 1+ years. ****This must be verified by an HCP****

Income Supports/Additional Benefits

	Description
Income Support	Maximum rate for a single adult is $1169/month. This includes $672 for basic needs and $497 for shelter costs. The maximum rate increases if a spouse or dependent(s) is included in the calculation.
Prescriptions	Prescription drug coverage for the recipient and their family for drugs listed in the Ontario Drug Benefit Formulary that are prescribed by an HCP.
Disability Related	Includes coverage for assistive/mobility devices, hearing aids, and guide dogs.
Vision/Dental	Routine eye exams (every 2 years) and with cost of eyeglasses and repairs. Coverage for basic dental services if over 18+; children will be enrolled in Healthy Smiles Program.

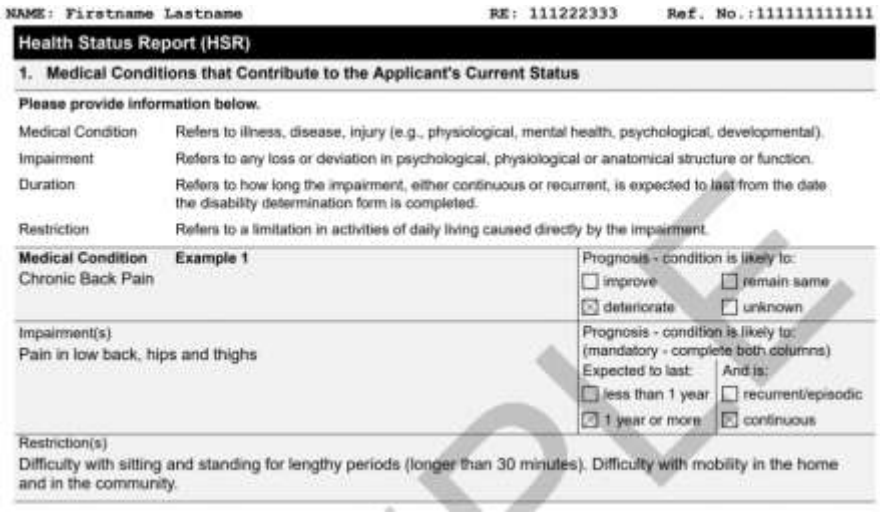
Key Facts

1. In 2019-2020 there was an average of just over 378,000 cases in the ODSP, and almost 522,00 beneficiaries.
2. Many people receiving ODSP will not have sufficient funds for the entirety of the month.
3. A large portion of people/families receiving ODSP will remain below the poverty line.
4. Patients in northern Ontario may receive additional income support (Remote Communities Allowance).
5. Recipients can only earn $200/month before their monthly allowance is reduced.

Completing ODSP Form

Step 2 of ODSP application focuses on determining disability – this is where HCP play an important role. Below is a step by step guide to completing ODSP forms.

1. Health status report – this collects information about their ongoing medical condition, **impairment, restrictions and expected duration of condition**. There is also an opportunity to add information about current treatments. **Make sure to attach supporting documentation** such as reports from X-rays/labs and clinical assessments or notes.



NAME: Firstname Lastname RE: 111222333 Ref. No.:111111111111

Health Status Report (HSR)

1. Medical Conditions that Contribute to the Applicant's Current Status

Please provide information below.

Medical Condition	Refers to illness, disease, injury (e.g., physiological, mental health, psychological, developmental).
Impairment	Refers to any loss or deviation in psychological, physiological or anatomical structure or function.
Duration	Refers to how long the impairment, either continuous or recurrent, is expected to last from the date the disability determination form is completed.
Restriction	Refers to a limitation in activities of daily living caused directly by the impairment.

Medical Condition **Example 1**
Chronic Back Pain

Prognosis - condition is likely to:
☐ improve ☐ remain same
☒ deteriorate ☐ unknown

Impairment(s)
Pain in low back, hips and thighs

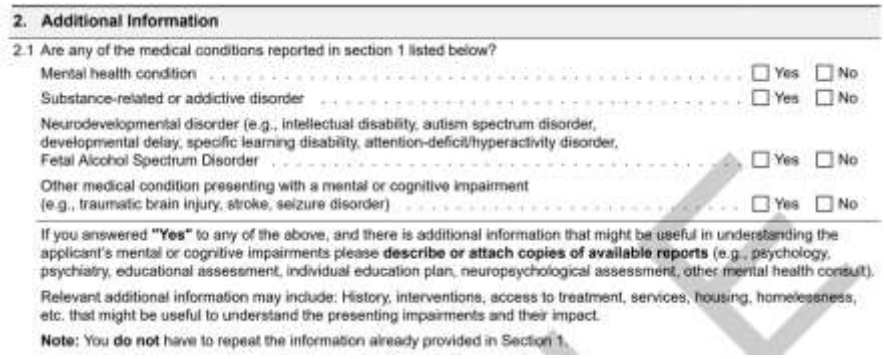
Prognosis - condition is likely to:
(mandatory - complete both columns)

Expected to last:	And is:
☐ less than 1 year	☐ recurrent/episodic
☒ 1 year or more	☒ continuous

Restriction(s)
Difficulty with sitting and standing for lengthy periods (longer than 30 minutes). Difficulty with mobility in the home and in the community.

For each medical condition contributing to disability, you will be asked to list the medical condition, the impairment caused by the medical condition, associated activity restrictions and prognosis.

Image to the left provides example for low back pain.



2. Additional Information

2.1 Are any of the medical conditions reported in section 1 listed below?

Mental health condition	☐ Yes ☐ No
Substance-related or addictive disorder	☐ Yes ☐ No
Neurodevelopmental disorder (e.g., intellectual disability, autism spectrum disorder, developmental delay, specific learning disability, attention-deficit/hyperactivity disorder, Fetal Alcohol Spectrum Disorder	☐ Yes ☐ No
Other medical condition presenting with a mental or cognitive impairment (e.g., traumatic brain injury, stroke, seizure disorder)	☐ Yes ☐ No

If you answered **"Yes"** to any of the above, and there is additional information that might be useful in understanding the applicant's mental or cognitive impairments please **describe or attach copies of available reports** (e.g., psychology, psychiatry, educational assessment, individual education plan, neuropsychological assessment, other mental health consult).

Relevant additional information may include: History, interventions, access to treatment, services, housing, homelessness, etc. that might be useful to understand the presenting impairments and their impact.

Note: You **do not** have to repeat the information already provided in Section 1.

Section 2 asks for additional information surrounding mental illness, neurodevelopmental disorders or other medical conditions leading to cognitive impairment. Should your patient have one of these conditions providing specialist reports/assessments, documented previous interventions/community supports and other social supports they utilize is encouraged.

2. Intellectual and emotional wellness scale (IF APPLICABLE) – this is especially important for **psychiatric, psychological and neurological** impairments. There are 28 items on this scale. Classify symptoms (e.g. attentional focus) according to **severity** and/or if **assistance from another individual is required.**

2.2. Intellectual and Emotional Wellness Scale (IEWS)

The checklist below consists of some features or symptoms that might be seen in mental health, substance use, neurocognitive and related conditions that can impact daily functioning.

Rate the symptoms in the context of the applicant's presenting conditions and impairments. For episodic symptoms, please describe how fluctuations in the severity level affect the patient.

Rating scale

DK = Don't know | **0** = Not present / Not at all | **1** = Mild / Just a little | **2** = Moderate / Quite a bit | **3** = Severe / Very Much

Symptoms	DK	0	1	2	3
1. Amotivation	☐	☐	☐	☐	☐
2. Anxiety	☐	☐	☐	☐	☐
3. Appetite Change: ☐ Increase ☐ Decrease	☐	☐	☐	☐	☐
4. Attention deficit	☐	☐	☐	☐	☐

The IEWS scale asks for a rating of how significantly each symptom impacts your patient's functioning on a 4 point scale provided to you. There is space to provide a more detailed description of symptoms with a fluctuating course at the bottom of the form.

3. Available Medical and other Information Related to Section 1 – this section asks for background **information on your relationship with the patient**, **physical exam** findings, history of **diagnostic imaging**, specialists **consults or allied health involvement**. If you have relevant reports it is suggested that **copies are attached to submission.**

4. Visual and Auditory – Section 4 and 5 ask for details of **visual** and/or **auditory** disabilities if applicable. You will be asked to **describe the disability** as well as if it **impacts certain areas of daily functioning.**

4. Visual

Note: Complete only if a visual condition or impairment is identified in section 1.

Date of Diagnosis (if known) (dd-mm-yyyy) | Most Recent Assessment Date (dd-mm-yyyy) ☐ See attached report

4.1 Snellen Visual Acuity Chart

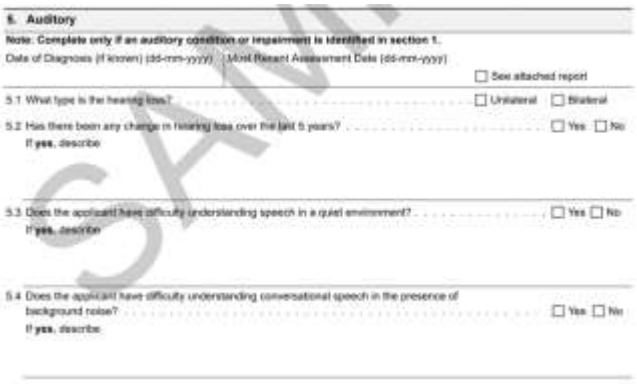
	Uncorrected		Corrected	
	Near	Distance	Near	Distance
Right Eye				
Left Eye				
Both Eyes				

4.2 Is there a visual field defect component in the visual impairment? ☐ Yes ☐ No

If yes, describe ▼ or ☐ attach report

4.3 Is there a change in ocular mobility (e.g., diplopia, strabismus) or deformities of the orbit that alter function? ☐ Yes ☐ No

If yes, describe ▼ or ☐ attach report



5. Auditory

Note: Complete only if an auditory condition or impairment is identified in section 1.

Date of Diagnosis (if known) (dd-mm-yyyy) | Most Recent Assessment Date (dd-mm-yyyy) ☐ See attached report

5.1 What type is the hearing loss? ☐ Unilateral ☐ Bilateral

5.2 Has there been any change in hearing loss over the last 5 years? ☐ Yes ☐ No

If yes, describe

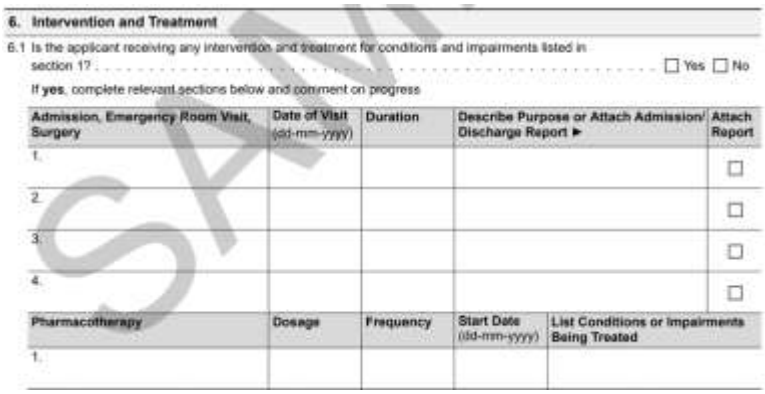
5.3 Does the applicant have difficulty understanding speech in a quiet environment? ☐ Yes ☐ No

If yes, describe

5.4 Does the applicant have difficulty understanding conversational speech in the presence of background noise? ☐ Yes ☐ No

If yes, describe

5. Intervention and Treatment – Section 6 asks you describe interventions including **hospitalization/ER/surgery, pharmacotherapy**, and **other applicable interventions** (from a list of 11 services offered). If no intervention reasoning for not yet providing treatment or discontinuing treatment is required. Again, relevant reports should be attached.



6. Intervention and Treatment

6.1 Is the applicant receiving any intervention and treatment for conditions and impairments listed in section 1? ☐ Yes ☐ No

If yes, complete relevant sections below and comment on progress

Admission, Emergency Room Visit, Surgery	Date of Visit (dd-mm-yyyy)	Duration	Describe Purpose or Attach Admission/ Discharge Report ►	Attach Report
1.				☐
2.				☐
3.				☐
4.				☐

Pharmacotherapy	Dosage	Frequency	Start Date (dd-mm-yyyy)	List Conditions or Impairments Being Treated
1.				

Specify details surrounding time spent in hospital as well as pharmacotherapy.

Interventions and Services	Start Date (dd-mm-yyyy)	End Date (dd-mm-yyyy)	Describe Response to Treatment or ►	Attach Report
1. Addiction services				☐
2. Chemotherapy				☐
3. Cognitive Behavioural Therapy (CBT)				☐
4. Counselling				☐
5. Occupational therapy				☐
6. Physiotherapy				☐
7. Psychotherapy				☐
8. Radiation				☐
9. Vocational rehabilitation				☐
10. Other rehabilitation (specify) ▼				☐
11. Other (e.g., Indigenous Healer) ▼				☐

If **no**, comment (e.g., pending, side effects, no definitive diagnosis, not available, poor insight)

Of the 11 listed interventions provide relevant details for interventions your patient is receiving or has received in the past.

6. Activities of Daily Living – This section asks the **degree to which the patient's medical condition(s) influences their ability to complete their activities of daily living** on a 4 point scale. There are 26 items on this scale. There are 3 additional follow up questions about the use of **assistive devices, guide animals or other social supports** in completing activities of daily living.

8. Activities of Daily Living Index (ADLI)

This section consists of a list of activities that seeks to understand the impact of the presenting impairments on the applicant's restrictions.

8.1 This information helps the ministry understand the direct impact of the impairments and restrictions listed in Section 1 on the applicant's current ability to perform and carry out each activity.

Rating scale

DK = Don't know	**0 = No limitation** (e.g., can carry out task completely without assistance)	**1 = Mild** (e.g., can complete task with minor assistance or extra time)	**2 = Moderate** (e.g., needs support in order to complete task; some supervision needed to get task done)	**3 = Severe** (e.g., completely unable to do task; task is done by someone else; does not understand the concept)

Please rate the limitation for each activity.

Activities	DK	0	1	2	3	Describe limitation, if needed
1. Bladder control	☐	☐	☐	☐	☐	
2. Bowel control	☐	☐	☐	☐	☐	
3. Bathing and self-cleaning	☐	☐	☐	☐	☐	

7. Submission – HCP will be required to attest that information on the form is true, that they are certified to practice and provide their contact information. Encourage patient to submit application within **90 days** of receiving application package. Most applications will be processed within in **10 business days** of submission. In additional to medical forms completed and signed by HCP patient must also include a **consent to release of medical information form**. They may choose to include a **self-report form** to describe how their disability impacts them.

Ontario Works

This section aims to provide an overview of OW including eligibility, income support/benefits received, and the application process.

Ontario Works (OW)

Eligibility

1. Age 16+
2. Resident of Ontario
3. Unable to cover living expenses

Income Support/Additional Benefits

	Description
Income Support	Individuals are eligible for a maximum of $733/month to help cover cost of shelter and other necessities. Maximum may increase if there are additional beneficiaries or dependents.
Health Benefits	Prescription Drug Coverage Dental Coverage (Healthy Smiles) Vision Care Travel/Transport for medical purposes Assistive/mobility devices
Other Benefits	Other Important benefits include assistance with moving/eviction costs.

Application

- Patients can complete application independently and online.
- Estimated time to complete application is 20-30min.
- Will need ID and tax documents (e.g. SIN, immigration papers, and tax returns) to complete application
- Online application will ask for names, DOB, status in Canada, address, housing costs, total monthly income, and other expenses including childcare.
- Applications should be reviewed within 4 business days, and OW office will set up meeting to confirm information/eligibility. If application is approved OW office will contact applicant within 4 business days to confirm method of payment and set up appointment to discuss employment related activities.

Employment Support

Unlike ODSP individuals receiving OW will typically be required to complete employment related activities to receive financial assistance.

These employment activities can include (but are not limited to) workshops for resume writing, job counselling, and job-specific training.

Costs incurred when participating in above employment activities such as transportation or childcare are typically covered. Additional funds are available for uniforms, tools, etc. when starting new job.

Canada Pension Plan

This section provides a description of the CPP including eligibility, income received and the CPP disability benefit.

Canada Pension Plan (CPP)

What is CPP?

This is a monthly benefit that replaces part of your income once an individual retires. Individual must apply in order to receive their pension.

Eligibility

1. Age 60+
2. Made at least 1 valid contribution to CPP (can be result of work you completed in Canada or receiving credits from former spouse or partner).

How much support is offered?

Monthly compensation varies depending on several key factors. The average monthly benefit if an individual chooses to start receiving their pension at age 65 is $679.16.
Factors influencing amount received include:

1. Average earnings
2. Contributions to CPP
3. Age you start receiving CPP (If individuals choose to receive pension earlier then monthly benefits will be smaller).

What is the CPP disability benefit?

This is an additional benefit offered to individuals **under the age of 65** who have made **sufficient contributions to the CPP**. These individuals must have **long-term disability that impairs their ability to work.** If your patient is receiving this benefit their **dependent children may also be eligible for monthly payments.**

Benefit Name	Age (Years)	Requirements
CPP Disability Benefit	Under 65	Not receiving CPP retirement pension
CPP Post-Retirement Disability Benefit	60-65	Receiving CPP for 15 months OR becoming disabled after starting to receive CPP

Emergency Relief

This section provides a brief description of the purpose of emergency relief, a few organizations/programs that can provide emergency relief in ON, and what to do if your patient is unable to apply to emergency relief or the emergency relief is not sufficient.

Emergency Relief

Overview

Conventional forms of social assistance may require several weeks for approval and payment to be made depending on the time of application. A patient may require assistance in a more immediate time frame. There are several different organizations/programs that can assist with providing emergency relief. A few examples are described below.

Examples of Emergency Assistance

Program	Description
Ontario Government Emergency Assistance	Can provide up to $733 of support (more if you have children) for up to 48 days. Examples of applicable emergencies include being evicted, leaving an abusive relationship or being impacted by COVID-19. Applications will be processed within 4 business days. **Individuals are not eligible if they are receiving ODSP or OW**
Low-income energy assistance program	Available to individuals who are behind on their energy bill, and at risk of having service disconnected. Households can receive a total grant of $500-$600 depending on how your house is heated.
Modest Needs	Charitable organization that offers grants designed to help individuals who live just above the poverty line, and therefore do not qualify for most social assistance programs. Can be used for unexpected expenses that individuals living paycheck to paycheck cannot afford or monthly bills that individuals cannot pay due to extenuating circumstances. Average grant is $750-$1250 and processed in

What else can you do to help?

1. Connect to free financial counselling service. For example, Woodgreen, which provides counselling in multiple languages.
2. Be aware of community projects or supports such as Caremongering Toronto.
3. Provide resources that can help reduce other costs of living. For example, a list of local food banks to allow money to be spent on rent instead of groceries.
4. Ontario 211 can help locate region specific support programs. The link to this resource is here: https://211ontario.ca/

HIV and AIDS

Screening, clinical presentation, anti-retroviral therapy, and exposure prophylaxis of HIV.

Risk Factors and Screening Indications

- **Who is at increased risk of HIV infection?**
    - Individuals with multiple of sexual partners
    - Individuals with anonymous sexual partners
    - Men with a history of sex with other men
    - Individuals who have been diagnosed with other STIs, hepatitis B or C
    - Sexual activity, sharing drug-use equipment, or receipt of blood or blood products for people from or who have travelled to HIV-endemic regions
    - Receipt of blood products in Canada prior to 1985
- **Who should get tested for HIV?**
    - Individuals who have requested testing
    - Individuals with signs and symptoms of HIV
    - Sexually active individuals who have not been tested for HIV
    - Individuals with illnesses linked to a weak immune system
    - Individuals who have shared drug equipment with another person whose HIV status is positive or unknown
    - Individuals who have had unprotected intercourse (anal or vaginal) with a partner whose HIV status is positive or unknown
    - Pregnant individuals or those planning a pregnancy, and their partners
    - Victims of sexual assault
    - Also consider in groups at increased risk of HIV

Vulnerable Populations

- **Sex workers**
    - Stigma, discrimination, and criminalization of sex work leads to fear of violence, harassment, and legal consequences, creating barriers to accessing treatment and preventative measures against HIV

- **Gay, bisexual, and other men who have sex with men**
    - Sexuality-based stigma, discrimination and violence can lead to delay or avoidance of healthcare and limits access to and use of HIV services

- **People who inject drugs**
    - Criminalization and the consequential punitive consequences of drug use can increase the use of unsafe practices and decrease the likelihood of accessing HIV services
    - Lack of access to harm-reduction services including needle replacement programs and opioid-substitution therapy exacerbates the impact of HIV in this population

- **Transgender and gender-diverse people**
    - Structural and societal discrimination and violence leads to avoidance of healthcare and a lack of access to HIV services
    - Experiencing discrimination in a healthcare setting decreases the likelihood of transgender individuals seeking care in the future
    - Erasure of transgender individuals results in a lack of detailed data on this population and thus an inability to meet their specific needs

- **Prisoners**
    - Prisons and closed settings are often neglected in strategies addressing HIV
    - Interruption in HIV-related care during transition into and out of prison can exacerbate the impact of HIV
    - Criminalization of sex work and drug use, lack of access to harm-reduction strategies such as needle and syringe access in prison, and failure to account for the specific concerns of LGBTQ+ individuals (such as incorrectly accommodating transgender individuals by their sex assigned at birth) results in overlapping and increased vulnerabilities for these populations and can increase the risk and impact of HIV

Clinical Manifestations

- **Acute HIV Infection**
  - Description
    - Period of acute infection immediately following exposure which results in the development of detectable anti-HIV antibodies
      - White blood cell count drops and viral load increases
      - Immune response is mounted
      - Symptoms develop approximately 2-4 weeks post-exposure
      - Seroconversion is complete around 10-24 weeks post-exposure and HIV viral load drops
  - CD4+ Count
    - Initial drop followed by a partial rebound after viral load peaks
  - Clinical Signs
    - May be asymptomatic
    - Persistent generalized lymphadenopathy
    - Constitutional symptoms
      - Fever
      - Fatigue
      - Myalgia
    - Oral
      - Thrush
      - Oral hairy leukoplakia
      - Herpes simplex virus lesions
    - Neurological
      - Headache
      - Painful, stiff neck
    - GI
      - Nausea
      - Diarrhea
      - Weight loss
    - Dermatologic
      - Varicella-zoster reactivation
      - Rash
    - Other opportunistic infections
      - Often more common in chronic late stage HIV but can occur here as well

- **TB Exacerbation**
  - Description
    - Latent infection with Mycobacterium tuberculosis may be reactivated with untreated HIV
    - TB may disseminate in the bloodstream to various organs leading to miliary TB
      - Higher mortality rate
  - CD4+ Count
    - Any
  - Clinical presentation
    - Fatigue
    - Weakness
    - Weight loss
    - Fever
    - Pulmonary tuberculosis
      - Chronic cough
      - Hemoptysis
  - Diagnosis
    - All individuals should be screened for latent TB by tuberculin skin test
  - Management
    - Treat if:
      - Inadequately treated or untreated TB
      - Tuberculin test induration ≥5mm and no previous prophylaxis
      - Recent exposure to TB
    - Isoniazid + pyridoxine
    - Respiratory isolation
    - Begin ART…
      - If CD4+ count <200 cells/uL OR
      - 4-8 weeks after initiation of anti-TB therapy (minimizes polypharmacy, overlapping toxicities, potential for immune reconstitution syndrome) OR
      - Immediately after clinical response to anti-TB therapy (aims to decrease AIDs events and mortality)

- **Oral hairy leukoplakia**
  - Description
    - Lesions of the mouth associated with infection of human herpesvirus 4 (Epstein-Barr virus)
    - Lesions are not pre-malignant
  - CD4+ Count
    - 235-468 cells/uL
  - Clinical Signs
    - Adherent lesions on the lateral sides of the tongue

                - Vary in character from irregular and hairy with projections to smooth and flat
                - Often asymmetric
                - Cannot be removed by scraping
            - Involvement of other areas may occur
                - Other tongue surfaces
                - Buccal mucosa
                - Gingiva
            - Spontaneous appearance and disappearance
            - Changes in sensation
                - Pain
                - Dysesthesia
                - Temperature sensitivity
            - Changes in taste
    - Diagnosis
        - Clinical + histological examination + confirmation of EBV DNA, RNA, or protein
        - Tissue biopsy only if abnormal appearance or ulcerations suggest malignancy
    - Management
        - Treatment not usually indicated
        - Usually reduces with HAART but may re-occur if decrease dose

- **Pneumocystis Jirovecii Pneumonia**
    - Description
        - Fungal pneumonia
    - CD4+ Count
        - <200 cells/uL
    - Clinical presentation
        - Progressive dyspnea
        - Non-productive cough
        - Hypoxemia
    - Diagnosis
        - CXR: diffuse, bilateral, symmetrical, ground-glass interstitial infiltrates
        - Bronchoalveolar lavage for definitive diagnosis
    - Management
        - Begin treatment prior to definitive diagnosis based on clinical, laboratory, and radiological findings indicating suspected PJP
        - 3 weeks TMP-SMX preferred, orally in mild-moderate disease, IV in patients with moderate-severe disease
            - Dapsone/TMP as second choice for ambulatory treatment
            - Clindamycin (+ oral primaquine) as second choice for IV treatment
        - Prednisone

- Adjunct for patients with moderate-severe PJP, concurrent with anti-Pneumocystis therapy
- Discontinue only after discontinuation of antimicrobials

- **Thrush**
  - Description
    - Oropharyngeal candidiasis
  - CD4+ Count
    - <200 cells/uL
  - Clinical presentation
    - Plaque-like lesions in the oral cavity
      - Creamy
      - White
      - Scrape off easily
  - Management
    - Topical agents for 7-14 days
      - Clotrimazole troches or nystatin suspension
    - OR Systemic therapy for 7-14 days
      - Oral fluconazole or itraconazole
      - Preferable for moderate to severe or recurrent infection

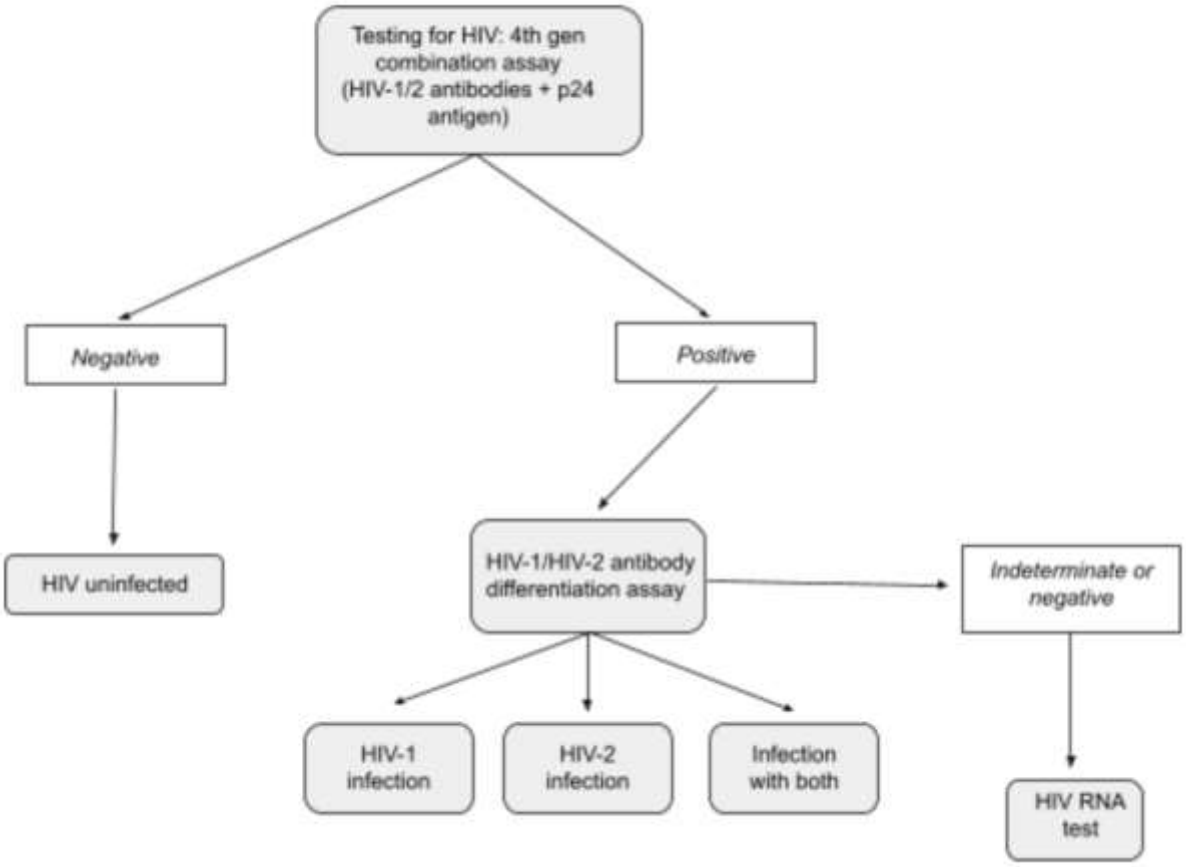
- **Kaposi Sarcoma**
  - Description
    - Soft tissue tumor caused by human herpesvirus 8
  - CD4+ Count: <200 cells/uL
  - Clinical Signs
    - Violaceous plaques on skin and mucocutaneous surfaces
    - Lymphedema
    - Ulceration or tissue invasion of lesions
    - Involvement of
      - Lungs
      - GI
      - Other organs
  - Diagnosis
    - Biopsy or excision followed by microscopic inspection + immunohistochemistry
  - Management
    - HAART can cause regression or resolution
    - Limited disease: local treatment to manage symptoms or cosmetic appearance
      - Intralesional chemotherapy for small lesions
      - Radiation therapy for larger lesions

        - Severe disease: use systemic hemotherapy alongside HAART
            - Initial therapy with a liposomal anthracycline preferred
            - Paclitaxel as an alternative

- **Toxoplasmosis**
    - Description
        - Toxoplasma gondii protozoan infection
        - Most common presentation is focal encephalitis
    - CD4+ Count
        - <50 cells/uL
    - Clinical presentation
        - Fever
        - Headaches
        - Seizures
        - Focal neurological deficits
        - Cognitive impairment
    - Diagnosis
        - Initiate empiric therapy if all of the following are met
            - CD4+ count <300 cells/uL
            - Appropriate clinical presentation
            - CT or MRI mass lesion suggestive of toxoplasmosis
        - Definitive diagnosis via lumbar puncture + CSF analysis and PCR
    - Management
        - Induction therapy for 6 weeks (longer if incomplete response)
            - Sulfadiazine + pyrimethamine + leukovorin
            - Monitor response
                - Clinically
                - Via MRI or CT if no clinical response in 2 weeks
        - Followed by maintenance therapy
            - Sulfadiazine + pyrimethamine+ leucovorin, at lower doses than induction therapy
            - May continue indefinitely if there is a response
            - OR until an alternate diagnosis is reached
            - OR until lack of symptoms and adequate, sustained response to HAART
                - CD4+ >200 cells/uL for ≥6mo

HIV Testing

- **Window period:** The period after infection with HIV where an individual is highly infectious but antibodies have not yet be produced, resulting in a negative test on antibody screening
- **3rd generation tests**: detect HIV antibody at 20-30 days post-exposure
- **Viral RNA and p24 antigen tests:** laboratory markers allowing diagnosis before antibodies have been produced at detectable levels
- **4th generation combination test**: p24 antigen + 3rd gen HIV antibody test; allows detection during viremic phase – window period of 15-20 days
- **Timeline for testing:**
    - At baseline
    - 3 weeks after suspected or known exposure
    - 3 months following a negative test, to confirm
    - If at risk continuously (therefore remaining in a continual window period), testing should be done more frequently than once per year



Pre-Treatment Work-up

- **Work-up to include at diagnosis:**
    - HIV viral load and genotype (resistance testing)
    - Basic bloodwork – i.e. CBC, electrolytes, creatinine, liver enzymes
    - CD4+ count
    - HLLA-B5701 allele testing (to rule out hypersensitivity reaction to Abacavir)
    - Tests to rule out co-infections:
        - STI testing – for syphilis, chlamydia, gonorrhea
        - TST – for latent TB
        - Toxoplasmosis serology
        - Schistosomiasis serology or Strongyloides serology (if appropriate based on travel history or origin from endemic region)

HIV Treatment – Antiretroviral Therapy (ART)

- **What is ART?**
  - Combined antiretroviral therapy (cART) or highly active retroviral therapy (HAART) consisting of at least 3 antiretroviral drugs should be initiated as soon diagnosis is confirmed
- **Classes of Antiretroviral drugs**
  - NRTI – nucleoside reverse transcriptase inhibitor
  - NNRTI – non-nucleoside reverse transcriptase inhibitor
  - PI – protease inhibitor
  - INSTI – integrase strand transfer inhibitor
  - Fusion inhibitor
  - CCR5 antagonist
  - CD4 T lymphocyte post-attachment inhibitor
  - Gp120 attachment inhibitor
- **What should a HAART regimen entail?**
  - A backbone of 2 NRTIs + another class
    - Other is usually INSTI, NNRTI, or boosted PI
- **Indications to Start Therapy**
  - Start at any CD4 count (START trial 2015)
  - Delay if CD4 < 200 + active TB co-infection
    - Wait until 4-8wk later (NOTE: unless CD4< 50 + TB co-infection, in which case you start within 2 weeks)
- **Recommended Initial Regimens:**
  - BIC/TAF/FTC
  - DTG/ABC/3TC (only for individuals who are HLA-B*5701 negative and without chronic HBV coinfection)
  - DTG plus (FTC or 3TC) plus (TAF or TDF)
  - DTG/3TC (except for individuals with HIV RNA > 500,000 copies/mL, HBV coinfection, or when ART is to be started before results of HIV genotypic resistance testing for reverse transcriptase)
- **Considerations when selecting a regimen**
  - Pretreatment HIV RNA level (viral load)
  - Pretreatment CD4 count
  - HIV genotypic drug resistance test results
  - HLA-B*5701 status
  - Comorbid conditions (e.g. cardiovascular disease, hyperlipidemia, renal disease, liver disease, osteoporosis/osteopenia, psychiatric illness, neurologic disease)
  - Coinfections → HBV, HCV, TB
  - Pregnancy and potential for pregnancy
  - Drug-drug interactions

Glossary

3TC: lamivudine
ABC: abacavir
BIC: Bictegravir
DTG : Dolutegravir
FTC: emtricitabine
TAF: tenofovir alafenamide
TDF: tenofovir disoproxil fumarate

- **Monitoring Treatment**
    - Viral load
        - Measure CD4 cell count and plasma viral load:
            - Every month while viral load is >40 copies
            - Every 2-3 months once viral load is <40 copies
    - CD4 count
    - % CD4 (of total lymphocytes)
    - CBC
    - Liver function
    - Renal function
    - Blood glucose (can be elevated in HIV)
    - Blood lipids (can be elevated due to antiretrovirals)

- **Immune Reconstitution Inflammatory Syndrome**
    - Pre-existing or previously sub-clinical infections may worsen or become apparent as the immune response improves following ART, associated with an increased inflammatory response
    - Frequently occurs with organisms including:
        - Mycobacterium tuberculosis
        - Pneumocystis jirovecii
        - Mycobacterium avium complex,
        - Cytomegalovirus
        - Cryptococcus neoformans
        - Herpes simplex virus
        - Hepatitis B virus
        - Human herpesvirus 8
    - Management
        - Continuation or commencement of treatment of opportunistic infection
        - Continuation of ART

Opportunistic Infection Prevention Strategies

- **Vaccination**
    - Potential mitigation of morbidity and mortality despite providing less-than-usual protection in the setting of a low CD4+ count and declining immune response
    - Inactivated vaccinations
        - Provide ASAP
    - Live attenuated vaccinations
        - Weigh risks and benefits
        - If severely immunosuppressed, wait for immune recovery to administer
        - Among others, the following may be considered, along with post-immunization serology to determine response
            - MMR in susceptible adults with CD4+ ≥200 cells/uL
                - 2 doses 3-6 months apart
            - Univalent varicella in susceptible adults with no history of varicella disease or vaccination and CD4+ count ≥200 cells/uL
                - 2 doses 3-6 months apart
            - Live herpes zoster in specific cases (see below)
        - The following are contraindicated
            - BCG
            - MMRV
            - Smallpox
            - Live typhoid
    - If vaccines were provided when severely immunosuppressed, consider re-vaccination once CD4+ count >200cells/μL if initial response is in doubt
    - Specific vaccines of note include:
        - Pneumococcal
            - 13-valent conjugate recommended
            - Polysaccharide should follow for:
                - ≥2 years old
                - ≥ 2 months after 13-valent conjugate
            - Polysaccharide re-immunization
                - 5 years after initial dose
        - Meningococcal conjugate
            - Quadrivalent conjugate vaccine recommended
                - At 2 months of age or at diagnosis
            - Boosters every 3-5 years
        - Hepatitis A
            - If indicated:
                - Individuals with risk factors such as
                    - Chronic liver disease (HBV, HCV included)

                - Living in a hepatitis A endemic community
                - Men who have sex with men
                - IV drug use
            - Pre-exposure prophylaxis for travel
                - With Ig
            - Post-exposure
                - With Ig if immune function is abnormal
    - Hepatitis B
        - Recommended
        - Double dose, on a 3 or 4 dose schedule
        - Booster if post-immunization anti-HB titers are <10IU/L
    - Influenza
        - Recommended annually for:
            - ≥6 months old
        - Inactivated type, live attenuated type is not recommended
    - Herpes zoster
        - Recombinant inactivated
            - Consider if indicated by:
                - Age
        - Live
            - If indicated by:
                - Age
                - AND CD4+ >200 cells/uL
                - AND inactivated version is contraindicated or unavailable

- **Screening for Common Co-Infections**
    - At diagnosis and yearly thereafter
        - Syphilis
        - Chlamydia
        - Gonorrhea
        - Trichomonas
    - At diagnosis or ART initiation
        - TB; and yearly thereafter if there is risk of exposure
        - Hepatitis A, B; and following vaccination to assess response
        - Hepatitis C; and yearly thereafter if at high risk

- **Antibiotic Prophylaxis**

Opportunistic Infection	Indication for primary prophylaxis	Indication for secondary prophylaxis	Prophylaxis	Discontinuing prophylaxis
Pneumocystis	CD4+ <200 cells/μL CD4+ fraction <14% Recurrent oral thrush	Previous episode of Pneumocystis jirovecii pneumonia	TMP-SMX	ART with CD4+ ≥200 cells/μL for ≥3 mo
Toxoplasma	CD4+ <100 cells/μL **AND** Positive toxoplasma IgG	Previously diagnosed toxoplasmosis	TMP-SMX	HAART with CD4+ ≥200 cells/μL for ≥3 mo for primary prophylaxis HAART with CD4+ ≥200 cells/μL for ≥6 mo with no symptoms of toxoplasma encephalitis for secondary prophylaxis

  - Little benefit due to low incidence in HIV/AIDs and the potential for drug interactions with HAART in:
    - Histoplasma
    - Mycobacterium Avium Complex
    - Bartonella Sp.
    - Cryptosporidium
    - Candida Spp.

  Instead consider beginning HAART as soon as possible and improving the CD4+ count to combat these infections

PrEP and PEP

PrEP – What is it?

- Pre-exposure prophylaxis for HIV, involving the use of an oral tablet containing 2 antiretroviral medications to prevent HIV infection
- For HIV-uninfected people who are at high, ongoing risk for HIV acquisition
- Used before and continuing after a potential exposure

Evaluation (before PrEP)	PrEP regimen guidelines	Monitoring (after PrEP)

• Confirm patient is at risk of acquiring HIV
• Perform baseline blood tests to:
  ○ Exclude acute or chronic HIV with 4th generation lab-based test
  ○ Assess renal function (tenofovir not recommended with eGFR <60mL/min*)
• Assess for pregnancy in those of childbearing age
• Screen for other infections in this high-risk group (Hep B, Hep C, STIs)
  ○ Vaccinate for Hep B if appropriate
	Tenofovir disoproxil fumarate 300mg/ emtricitabine 200mg (**Truvada**)*
	• 1 tablet po daily
	
	Tenofovir alafenamide/emtricitabine (**Descovy**)
	• Not OHIP covered but for those with private insurance could be a better option RE: renal dysfunction and decreased bone mineral density due to the TAF formulation
	• Not enough evidence to support its use in cisgender women or trans men due to decreased concentrations of TAF in the cervicovaginal mucosa
		After the first 30 days
		• Test for HIV and other STIs, monitor for side effects, provide adherence and risk-reduction counseling
		Every 3 months
		• Re-evaluate HIV status (confirm negative)
		• Renew prescriptions (90-day refill)
		• Test for STIs (syphilis, gonorrhea, chlamydia)
		• Assess renal function (creatinine)
		• Assess for pregnancy where appropriate
		At every visit
		• Assess side effects, adherence, and HIV acquisition risk behaviours

- **How quickly does PrEP provide protection?**
  - Up to 7 days for rectal tissue and plasma
  - Up to 21 days for cervicovaginal tissue
- **Adverse Effects**
  - GI effects (nausea, vomiting, diarrhea), headaches, and dizziness are most common)
  - May be associated with bone mineral density reduction
  - Tenofovir may be associated with decreased renal function
- **"On Demand" PrEP**
  - **2-1-1** schedule → take 2 pills 2-24h before sex, 1 pill after the first dose, then 1 pill after the second dose
- **Other considerations**
  - Those with gonorrhea or chlamydia infection have increased risk of HIV infection → discuss PrEP as an option

PEP – What is it?

- 3 HIV medication combination that an HIV-uninfected person takes for 4 weeks to reduce their risk of infection after a possible or probable exposure
- Involves use of antiretrovirals for 28 days after a specific HIV exposure
- Must be started within 72h of exposure, preferably asap

- **When to use**
  - Non-occupational exposures (e.g. sexual exposure, injection drug use)
  - Occupational exposures (e.g. needlestick injury, healthcare worker exposure)
- **Recommended regimen**
  - Tenofovir-based 3-drug regimens involving dual NRTI backbone + integrase inhibitor or protease Inhibitor and booster drug
- **Side effects**
  - Generally well-tolerated
  - Can cause side effects like:
    - Nausea, vomiting, fatigue, diarrhea
  - Tenofovir associated with osteoporosis
  - Tenofovir should be avoided with eGFR <60

GLOSSARY
DRV: Darunavir
DTG: Dolutegravir
FTC: Emtricitabine
RAL: Raltegravir
r: Ritonavir
TDF: Tenofovir disoproxil fumarate

Evaluation (before PEP)	PEP regimen Guidelines	Monitoring (after PEP)
• HIV test (PEP only used in HIV-negative individuals); 4th gen serology test • Assess hepatic and renal function • Evaluate for STI or hepatitis infections	TDF/FTC (300mg/200mg) qd + RAL (400mg) po bid or DTG (50mg) qd or DRV (800mg) qd + r (100mg) qs	Follow-up HIV test 12 weeks after exposure (8 week after finishing PEP)

- **Considerations**
  - Individuals needing non-occupational PEP recurrently (e.g. recurrent sexual exposure) can be eligible for PrEP → have discussion about this option

References

Indigenous Health

1. Loppe, C. and Wien, F. Understanding Indigenous health inequities through a social determinants model. National Collaborating Centre for Indigenous Health; 2022. [25 June 2022]. Available from: https://www.nccih.ca/Publications/Lists/Publications/Attachments/10373/Health_Inequalities_EN_Web_2022-04-26.pdf
2. Student Success Centre. Land Acknowledgements: A Guide. McMaster University; date unknown. [cited 26 June 2022]. Available from: https://healthsci.mcmaster.ca/docs/librariesprovider59/resources/mcmaster-university-land-acknowledgment-guide.pdf?sfvrsn=7318d517_2
3. Currie RF. Respect, trust, treaties and reconciliation. Circles for Reconciliation. 2020:1-0.
4. Future Cities Canada. Two Row and Dish With One Spoon Wampum Covenants. Future Cities Canada; 2022. [updated Feb 2022; cited 26 Jun 2022]. Available from: https://futurecitiescanada.ca/portal/wp-content/uploads/sites/2/2022/02/fcc-civic-indigenous-tool3-teaching-twodishonespoon.pdf
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. Toronto: Wellesley Institute; 2015. [cited 29 June 2022].
6. Mattison CA, Doxtater K, Lavis JN. Care for Indigenous Peoples. Ontario's Health System: Key Insights for Engaged Citizens, Professionals and Policymakers. 2016:349-73.
7. Coates, K. The Indian Act and the Future of Aboriginal Governance in Canada. Research Paper for the National Centre for First Nations Governance; 2008. Available here: https://fngovernance.org/wp-content/uploads/2020/05/coates.pdf
8. Indian Act, R.S.C., 1985, c. 1-5. Available here: https://laws-lois.justice.gc.ca/eng/acts/i-5/page-1.html
9. R. v. Powley, [2003] 2 S.C.R. 207, 2003 SCC 43. Supreme Court Judgments; 2003. Available from: https://decisions.scc-csc.ca/scc-csc/scc-csc/en/item/2076/index.do?r=AAAAAQAGcG93bGV5AAAAAAAAAQ
10. Ataullahjan, S., Bernard, W., and Hartling, N. Forced and coerced sterilization of persons in Canada. Standing Senate Committee on Human Rights; 2021. [cited 25 June 2022]. Available from: https://sencanada.ca/content/sen/committee/432/RIDR/Reports/2021-06-03_ForcedSterilization_E.pdf

Anti-racism

1. Johnson AG. The Blackwell Dictionary of Sociology: A User's Guide to Sociological Language. 2nd ed. Malden, MA: Blackwell; 2000.

2. Office of Disease Prevention and Health Promotion. Disparities. Healthy People 2020. https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities. Accessed January 18, 2019.

3. Orgera K, Artiga S. Disparities in Health and Health Care: Five Key Questions and Answers. Kaiser Family Foundation. https://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/#footnote-267499-2. Published 2018. Accessed January 19, 2019.

4. Whitehead M, Dahlgren G. Concepts and Principles for Tackling Social Inequities in Health: Levelling up Part 1. Copenhagen; 2006.

5. Staats C, Capatosto K, Wright RA, Contractor D. State of the Science: Implicit Bias Review 2015.; 2015. http://kirwaninstitute.osu.edu/wp-content/uploads/2015/05/2015-kirwan-implicit-bias.pdf. Accessed January 19, 2019.

6. Crenshaw K. Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics University of Chicago Legal Forum 1989. http://chicagounbound.uchicago.edu/uclfhttp://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8. Accessed January 22, 2019.

7. YW Boston. What is intersectionality, and what does it have to do with me? YW Boston Blog. https://www.ywboston.org/2017/03/what-is-intersectionality-and-what-does-it-have-to-do-with-me/. Published 2017. Accessed January 22, 2019.

8. Boston Public Health Commission. Racial Justice and Health Equity Initiative: Core Workshop Facilitator's Guide. 2011.

9. Sue DW. Microaggressions in everyday life: Race, gender, and sexual orientation. John Wiley & Sons; 2010.

10. Nadal KL. The Racial and Ethnic Microaggressions Scale (REMS): Construction, Reliability, and Validity. Journal of Counseling Psychology. 2011;58(4):470-480.

11. Derald Wing Sue SA, Michael N. Awad, Elizabeth Glaeser, Cassandra Z. Calle and Narolyn Mendez. Disarming Racial Microaggressions: Microintervention Strategies for Targets, White Allies, and Bystanders. American Psychologist. 2019;74(1):128-142.

12. Ackerman-Barger K, Valderma-Wallace C, Latimore D, Drake C. Stereotype Threat Susceptibility Among Minority Health Professions Students. Journal of Best Practices in Health Professions Diversity. 2016;9(2):1232-1246.

2SLGBTQ+ Healthcare

Family Planning:

1. Amato, P. Fertility options for transgender persons [Internet]. UCSF Gender Affirming Health Program. 2016. Available from: https://transcare.ucsf.edu/guidelines/fertility

2. Government of Ontario. Get fertility treatments [Internet]. ontario.ca. 2021. Available from: https://www.ontario.ca/page/get-fertility-treatments

3. National LGBTQIA+ Health Education Center. Pathways to Parenthood for LGBT People [Internet]. The Fenway Institute. 2016. Available from: https://www.lgbtqiahealtheducation.org/wp-content/uploads/Pathways-to-Parenthood-for-LGBT-People.pdf

MSM Health:

1. Centers for Disease Control and Prevention. Gay and Bisexual Men's Health. [Internet]. US Department of Health and Human Services. 2016. Available from : https://www.cdc.gov/msmhealth/for-your-health.html

2. Challacombe, L. The Epidemiology of HIV in Canada. [Internet]. CATIE: Canada's source for HIV and hepatitis C information. 2021. Available from: https://www.catie.ca/the-epidemiology-of-hiv-in-canada

3. Goodhead.ca. About. [Internet]. Engage study. n.d. Available from: https://goodhead.ca/en/about#research

4. Ontario HIV Treatment Network. Men who have sex with men. [Internet]. Ontario HIV treatment network. n.d. Available from: https://www.ohtn.on.ca/research-portals/priority-populations/men-who-have-sex-with-men/

5. Public Health Agency of Canada. Summary: estimates of HIV incidence, prevalence and Canada's progress on meeting the 90-90-90 HIV targets, 2016. HIV Surveillance Supplemental Report. 2018.

6. Weiss, E. Anal cancer: information to get you out of the dark. [Internet]. The University of British Columbia Faculty of Medicine: This Changed My Practice. 2019. Available from: https://thischangedmypractice.com/anal-cancer-info-dare/

WSW Health:

1. Centers for Disease Control and Prevention. Sexually Transmitted Infections Treatment Guidelines, 2021: WSW and WSWM. [Internet]. US Department of Health and Human Services. 2021. Available from : https://www.cdc.gov/std/treatment-guidelines/wsw.htm

2. Knight DA, Jarrett D. Preventive health care for women who have sex with women. American family physician. 2017 Mar 1;95(5):314-21.

3. OHTN Rapid Response Service. Rapid Review: HIV prevention for women who have sex with women. Ontario HIV Treatment Network. 2010. Available from:

https://www.ohtn.on.ca/Pages/Knowledge-Exchange/Rapid-Responses/Documents/RR19-2010-WSW-Prevention.pdf

Trans Health:

1. Hsiao KT, Care UT. Screening for cervical cancer in transgender men. [Internet]. UCSF Gender Affirming Health Program. 2016. Available from: https://transcare.ucsf.edu/guidelines/cervical-cancer
2. Potter, M. Tips for providing paps to trans men. Sherbourne Health Centre. n.d. Available from: https://www.rainbowhealthontario.ca/wp-content/uploads/2020/04/Tips_Paps_TransMen.pdf
3. Sallans RK. Six Tips for Giving Good Health Care to Anyone With a Cervix. AMA Journal of Ethics. 2020 Feb 1;22(2):168-75.
4. Wesp, L. Transgender patients and the physical examination. [Internet]. UCSF Gender Affirming Health Program. 2016. Available from: https://transcare.ucsf.edu/guidelines/physical-examination
5. Zevin, B. Testicular and scrotal pain and related complaints. [Internet]. UCSF Gender Affirming Health Program. 2016. Available from: https://transcare.ucsf.edu/guidelines/testicular-pain

Gender Affirming Care:

1. Mayo Clinic. Feminizing hormone therapy. [Internet]. Mayo clinic. 2021. Available from: https://www.mayoclinic.org/tests-procedures/feminizing-hormone-therapy/about/pac-20385096
2. Mayo Clinic. Masculinizing hormone therapy. [Internet]. Mayo clinic. 2021. Available from: https://www.mayoclinic.org/tests-procedures/masculinizing-hormone-therapy/about/pac-20385099
3. Rainbow Health Ontario. Masculinizing Hormone Therapy. [Internet]. Sherbourne Health. 2020. Available from: https://www.rainbowhealthontario.ca/TransHealthGuide/gp-mascht.html#back
4. Rainbow Health Ontario. Feminizing Hormone Therapy. [Internet]. Sherbourne Health. 2020. Available from: https://www.rainbowhealthontario.ca/TransHealthGuide/gp-femht.html#back
5. Trans Primary Care. Point of care guides. [Internet]. Rainbow Health Ontario. 2016. Available from: https://bmc1.utm.utoronto.ca/~kelly/transprimarycare/resources.html

Physical Alteration Practices and Safety:

1. Trans Care BC. Binding, Packing, Tucking & Padding. [Internet]. Provincial Health Services Authority. n.d. Available from: http://www.phsa.ca/transcarebc/care-support/transitioning/bind-pack-tuck-pad

2. Trans Care BC. Things to know about tucking. [Internet]. Provincial Health Services Authority. n.d. Available from: http://www.phsa.ca/transcarebc/Documents/HealthProf/Tucking-Handout.pdf

Considerations for Clinical Practice:

1. Abramovich A, de Oliveira C, Kiran T, Iwajomo T, Ross LE, Kurdyak P. Assessment of Health Conditions and Health Service Use Among Transgender Patients in Canada. JAMA Netw Open. 2020;3(8):e2015036. doi:10.1001/jamanetworkopen.2020.15036

2. Bauer GR, Scheim AI, Pyne J, Travers R, Hammond R. Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada. BMC public health. 2015 Dec;15(1):1-5.

3. Scheim AI, Bauer GR, Shokoohi M. Drug use among transgender people in Ontario, Canada: Disparities and associations with social exclusion. Addictive Behaviors 2017; 72:151-158. doi: http://doi.org/10.1016/j.addbeh.2017.03.022.

4. Scheim AI, Bauer GR, Shokoohi M. Heavy episodic drinking among transgender persons: Disparities and predictors. Drug and Alcohol Dependence 2016; 167:156-162. doi: http://dx.doi.org/10.1016/j.drugalcdep.2016.08.011.

Refugee Health

1. Government of Canada. How Canada's refugee system works. [Internet]. Ottawa: Government of Canada; [updated 2019 Nov 11; cited 2022 Jan 9]. Available from: https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/canada-role.html

2. United Nations High Commissioner for Refugees. What is a refugee. [Internet]. Geneva: United Nations High Commissioner for Refugees; c2022; [cited 2022 Jan 9]. Available from: https://www.unhcr.org/what-is-a-refugee.html

3. Government of Canada. Groups of Five: About the process. [Internet]. Ottawa: Government of Canada; [updated 2021 Nov 24; cited 2022 Jan 9]. Available from: https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/help-outside-canada/private-sponsorship-program/groups-five.html

4. Government of Canada. Groups of Five: Who can apply. [Internet]. Ottawa: Government of Canada; [updated 2021 Nov 24; cited 2022 Jan 9]. Available from: https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/help-outside-canada/private-sponsorship-program/groups-five/eligibility.html

5. Government of Canada. Community Sponsors: About the process. [Internet]. Ottawa: Government of Canada; [updated 2021 Nov 24; cited 2022 Jan 9]. Available from: https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/help-outside-canada/private-sponsorship-program/community-sponsors.html

6. Government of Canada. Claim refugee status from inside Canada: Who can apply. [Internet]. Ottawa: Government of Canada; [updated 2021 Apr 4; cited 2022 Jan 9].

Available from: https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/claim-protection-inside-canada/eligibility.html

7. Government of Canada. Interim Federal Health Program: What is covered. [Internet]. Ottawa: Government of Canada; [updated 2021 Sept 10; cited 2022 Jan 9]. Available from: https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/help-within-canada/health-care/interim-federal-health-program/coverage-summary.html

8. Government of Canada. Immigration Medical Exam (IME). [Internet]. Ottawa: Government of Canada; [updated 2019 Apr 23; cited 2022 Jan 10]. Available from: https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/operational-bulletins-manuals/standard-requirements/medical-requirements/exam.html

9. Pottie K, Gruner D, Ferreyra M, Ratnayake A, Ezzat O, Ponka D, Rashid M, Kellam H, Sun R., Miller K., & Merritt K. Refugees and Global Health: A Global Health E-Learning Program, [Internet]. Canadian Collaboration for Immigrant and Refugee Health (CCIRH) and the University of Ottawa, Canada. [cited 2022 Jan 9] Available from www.ccirhken.ca/eLearning

10. Warmington R, Miller K, Pottie K. Evidence-Based Preventive Care Checklist for New Immigrants and Refugees. [Internet]. Canadian Collaboration for Immigrant and Refugee Health and the University of Ottawa, Canada; 2012 [cited 2022 Jan 9]. Available from: http://www.ccirhken.ca/ccirh/checklist_website/index.html

11. Ontario Council of Agencies Serving Immigrants. OCASI Guidelines on Trauma and Violence Informed Approaches for Agencies Serving Immigrants and Refugees. [Internet]. Toronto: Ontario Council of Agencies Serving Immigrants. [Cited 2022 Jan 9]. Available from: https://ocasi.org/sites/default/files/tvia-guide-english-online.pdf

12. Arya N, Redditt VJ, Talavlikar R, Holland T, Brindamour M, Wright V, Saad A, Beukeboom C, Coakley A, Rashid M, Pottie K. Caring for refugees and newcomers in the post-COVID-19 era: Evidence review and guidance for FPs and health providers. Can Fam Physician. 2021 Aug;67(8):575-581. doi: 10.46747/cfp.6708575.

13. Pottie K, Greenaway C, Feightner J, Welch V, Swinkels H, Rashid M, Narasiah L, Kirmayer LJ, Ueffing E, MacDonald NE, Hassan G, McNally M, Khan K, Buhrmann R, Dunn S, Dominic A, McCarthy AE, Gagnon AJ, Rousseau C, Tugwell P; coauthors of the Canadian Collaboration for Immigrant and Refugee Health. Evidence-based clinical guidelines for immigrants and refugees. CMAJ. 2011 Sep 6;183(12):E824-925. doi: 10.1503/cmaj.090313.

14. Pottie K, Greenaway C, Feightner J, Welch V, Swinkels H, Rashid M, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ. 2011 Sep 6;183(12): E824-925.

15. Horsburgh CR Jr. Treatment of latent tuberculosis infection in HIV-uninfected nonpregnant adults. In: von Reyn CF, Baron EL, editors. UpToDate. [Internet]. UpToDate Inc; 2021 [updated 2021 Apr 26; cited 2022 Jan 9]. Available from:

https://www.uptodate.com/contents/treatment-of-latent-tuberculosis-infection-in-hiv-uninfected-nonpregnant-adults

16. Sterling, TR. Treatment of drug-susceptible pulmonary tuberculosis in HIV-uninfected adults. In: Bernardo J, Baron EL, editors. UpToDate. [Internet]. UpToDate Inc; 2021 [updated 2021 Sept 10; cited 2022 Jan 9]. Available from: https://www.uptodate.com/contents/treatment-of-drug-susceptible-pulmonary-tuberculosis-in-hiv-uninfected-adults

17. Lok ASF. Hepatitis B virus: Overview of management. In: Esteban R, Mitty J, editors. UpToDate. [Internet]. UpToDate Inc; 2021 [updated 2021 Jul 30; cited 2022 Jan 9]. Available from: https://www.uptodate.com/contents/hepatitis-b-virus-overview-of-management

18. Shah H, Bilodeau M, Burak KW, Cooper C, Klein M, Ramji A, Smyth D, Feld JJ; Canadian Association for the Study of the Liver. The management of chronic hepatitis C: 2018 guideline update from the Canadian Association for the Study of the Liver. CMAJ. 2018 Jun 4;190(22):E677-E687. doi: 10.1503/cmaj.170453.

19. Leder K, Weller PF. Strongyloidiasis. In: Ryan ET, Baron EL, editors. UpToDate. [Internet]. UpToDate Inc; 2021 [updated 2021 Jan 5; cited 2022 Jan 9]. Available from: https://www.uptodate.com/contents/strongyloidiasis

20. Soentjens P, Clerinx J. Schistosomiasis: Treatment and prevention. In: Weller PF, Baron EL, editors. UpToDate. [Internet]. UpToDate Inc; 2021 [updated 2021 Oct 1; cited 2022 Jan 9]. Available from: https://www.uptodate.com/contents/schistosomiasis-treatment-and-prevention

21. Daily J. Treatment of uncomplicated falciparum malarium in nonpregnant adults and children. In: Ryan ET, Kaplan SL, Baron EL, editors. UpToDate. [Internet]. UpToDate Inc; 2021 [updated 2021 Oct 7; cited 2022 Jan 9]. Available from: https://www.uptodate.com/contents/treatment-of-uncomplicated-falciparum-malaria-in-nonpregnant-adults-and-children

22. Government of Canada. Chapter 7 – Treatment of malaria: Canadian recommendations for the prevention and treatment of malaria. Ottawa: Government of Canada; [updated 2021 Mar 10; cited 2022 Jan 9]. Available from: https://www.canada.ca/en/public-health/services/catmat/canadian-recommendations-prevention-treatment-malaria/chapter-7-treatment.html

Healthcare Considerations for Sex Workers

1. Lam E [Internet]. Toronto: Butterfly (Asian and Migrant Sex Workers Support Network). Understanding Migrant Sex Workers; August 2018 [cited 2021Dec 15]. Available from: https://576a91ec-4a76-459b-8d05-4ebbf42a0a7e.filesusr.com/ugd/5bd754_5826c5ca074f408988ee248d5f614219.pdf

2. Malla A, Lam E, van der Meulen E, Peng H [Internet]. Toronto: Butterfly (Asian and Migrant Sex Workers Support Network). Beyond tales of trafficking: a needs assessment of Asian migrant sex workers in Toronto. 2019 [coted 2021 Dec 15]. Available from:

https://576a91ec-4a76-459b-8d05-4ebbf42a0a7e.filesusr.com/ugd/5bd754_a35d8e085c21475fa97e1ff759d26648.pdf

3. Benoit C, Smith M, Jansson M, Magnus S, Maurice R, Flagg J, et al. Canadian Sex Workers Weigh the Costs and Benefits of Disclosing Their Occupational Status to Health Providers. Sex Res Soc Policy. 2019 Sep;16(3):329–41.

4. Berus C [Internet]. Ottawa: University of Ottawa. The framing of sex work and its impact on health outcomes: a comparative analysis of Canada, Australia and Sweden. 2013 Sep 09 [cited 2021 Dec 15]. Available from: https://ruor.uottawa.ca/bitstream/10393/26064/1/BERUS%2C%20Catherine%2020135.pdf

5. Sawicki DA, Meffert BN, Read K, Heinz AJ. Culturally competent health care for sex workers: an examination of myths that stigmatize sex work and hinder access to care. Sexual and Relationship Therapy. 2019 Jul 3;34(3):355–71.

6. The Needs Assessment Team [Internet]. Toronto: Regent Park Community Health Centre. Street Based Sex Workers Need Assessment Survey. 2014 [cited 2021 Dec 15]. Available from: https://www.streethealth.ca/downloads/sex-workers-needs-assessment.pdf

Healthcare for Incarcerated or Detained Patients

1. Miller A. Providing principled health care in prison. CMAJ. 2013 Mar;185(4):E183-E184; DOI : https://doi.org/10.1503/cmaj.109-4406
2. Corrections and conditional release statistical overview, 2010. Ottawa (ON): Public Safety Canada; 2010. Available from https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/ccrso-2019/ccrso-2019-en.pdf
3. Statistics Canada. Table 35-10-0014-01 Adult admissions to correctional services. 2022. DOI: https://doi.org/10.25318/3510001401-eng
4. Singh D, Prowse S, Anderson M. CMAJ. 2019 May;191(18):E487-E488. DOI: https://doi.org/10.1503/cmaj.181437.
5. Owusu-Bempah A, Kanters S, Druyts E, Toor K, Muldoon KA, Farquhar JW, Mills EJ. Years of life lost to incarceration: inequities between Aboriginal and non-Aboriginal Canadians. BMC Public Health. 2014 Dec;14(1):1-6.
6. Statistics Canada. Adult and youth correctional statistics, 2020/2021. Available from: https://www150.statcan.gc.ca/n1/daily-quotidien/220420/dq220420c-eng.htm.
7. Patterson EJ. The dose–response of time served in prison on mortality: New York State, 1989–2003. American Journal of Public Health. 2013 Mar;103(3):523-8.
8. Kouyoumdjian FG, Kiefer L, Wobeser W, Gonzalez A, Hwang SW. Mortality over 12 years of follow-up in people admitted to provincial custody in Ontario: a retrospective cohort study. Canadian Medical Association Open Access Journal. 2016 Apr 27;4(2):E153-61.
9. Pager D, Western B, Sugie N. Sequencing disadvantage: Barriers to employment facing young black and white men with criminal records. The annals of the American academy of political and social science. 2009 May;623(1):195-213.

10. Columbia B, Kendall PR. Health, Crime, and Doing Time: Potential Impacts of the Safe Streets and Communities Act (former Bill C-10) on the Health and Well-being of Aboriginal People in BC. Office of the Provincial Health Officer; 2013.
11. Kouyoumdjian F, Schuler A, Matheson FI, Hwang SW. Health status of prisoners in Canada: Narrative review. Can Fam Physician. 2016 Mar;62(3):215-22. PMCID: PMC4984599.
12. The Lancet. Caring for patients who have been tortured in detention. 2019 Jun;S0140-6736(19)31424-2. DOI: https://doi.org/10.1016/S0140-6736(19)31424-2.
13. Mukhopadhyay B, Jonathan Y, Bodkin C. Rowhani M, and Alavian S. Caring for people who are detained. 2021. Available from: https://caringforpeople.squarespace.com/zine.
14. CMPA. Physician interactions with police. 2019. Available from: https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2011/physician-interactions-with-police
15. CMPA. When to disclose confidential information. 2015. Available from: https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2015/when-to-disclose-confidential-information

Opioid Use Disorder

1. British Columbia Centre on Substance Use and B.C. Ministry of Health. A Guideline for the Clinical Management of Opioid Use Disorder. Jun 5, 2017. Available from: https://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf

2. Centre for Addiction and Mental Health. Opioid Agonist Therapy: A Synthesis of Canadian Guidelines for Treating Opioid Use Disorder. May 2021. Available from: https://www.camh.ca/-/media/files/professionals/canadian-opioid-use-disorder-guideline2021-pdf.pdf

3. Thompson, M. Street Opioid Resuscitation Recommendations for Pre-hospital and Hospital Care. Ontario Poison Centre. Aug 1, 2018. Available from: https://www.ontariopoisoncentre.ca/siteassets/pdfs/english/76897-hopsitalguidelines_naloxone_aug18.pdf

Harm Reduction

1. Canadian Mental Health Association. Harm Reduction [Internet]. n.d. Available from https://ontario.cmha.ca/harm-reduction/ .

2. Marshall, T., Viste, D., Ritchie, K., et al. National Overdose Response Service (NORS): Report. Jan 2022. Available from: http://nors.ca .

3. National Harm Reduction Coalition. Principles of Harm Reduction [Internet]. 2020. Available from: https://harmreduction.org/about-us/principles-of-harm-reduction/ .

Income Supports

ODSP:

1. Government of Ontario. Ontario Disability Support Program [Internet]. Mar 27, 2022. Available from: https://www.ontario.ca/page/ontario-disability-support-program .

2. Government of Ontario. Ontario Disability Support Program: Healthcare Professional's Guide. 2013. Available from: https://www.mcss.gov.on.ca/documents/en/mcss/social/publications/HCP_Guide.pdf.

3. Maytree. Social Assistance Summaries 2020: Canada. June 2021. Available from: https://maytree.com/wp-content/uploads/Social_Assistance_Summaries_All_Canada.pdf .

4. Trick, S. How the Ontario Disability Support Program can make it tough to find- and hold down- a job. TVO today [Internet]. Nov 21, 2018. Available from: https://www.tvo.org/article/how-the-ontario-disability-support-program-can-make-it-tough-to-find-and-hold-down-a-job .

OW:

1. Government of Ontario. Ontario Works [Internet]. Mar 27, 2022. Available from: https://www.ontario.ca/page/ontario-works .

2. Government of Ontario. Social Assistance [Internet]. Nov 1, 2020. Available from: https://www.ontario.ca/page/social-assistance .

CPP:

1. Government of Canada. CPP Retirement Pension [Internet]. Apr 14, 2022. Available from : https://www.canada.ca/en/services/benefits/publicpensions/cpp.html .

Emergency Relief:

1. Government of Ontario. Apply for emergency assistance [Internet]. Apr 9, 2020. Available from: https://www.ontario.ca/page/apply-emergency-assistance .

2. Holland Bloorview Kids Rehabilitation Hospital. Family Tipsheet: Emergency funding sources and access to basic necessities [Internet]. n.d. Available from: https://hollandbloorview.ca/services/family-workshops-resources/family-resource-centre/covid-19-emergency-funding .

3. Modest Needs Foundation. Frequently asked questions for individual applicants [Internet]. n.d. Available from: https://www.modestneeds.org/for-applicants/faq.asp .

4. Ontario Energy Board. Low-income Energy Assistance Program. Consumer Information and Protection [Internet]. n.d. Available from: https://www.oeb.ca/consumer-information-and-protection/bill-assistance-programs/low-income-energy-assistance-

program#:~:text=Low%2Dincome%20customers%20can%20get,face%20having%20your%20service%20disconnected

HIV and AIDS

1. Government of Canada. Human Immunodeficiency Virus - HIV Screening and Testing. [Internet]. Ottawa: Government of Canada; [updated 2014; cited 2021 Sep 01]. Available from: https://www.canada.ca/en/public-health/services/hiv-aids/hiv-screening-testing-guide.html

2. Gale-Rowe M, Dodds J, Paquette D, Wong T. Synopsis of the Human Immunodeficiency Virus (HIV) screening and testing guide. Canada Communicable Disease Report [Internet]. [Updated 2013 Nov; cited 2022 Jan 04]; 39(1):2–8. Available from: https://www.canada.ca/en/public-health/services/reports-publications/canada-communicable-disease-report-ccdr/monthly-issue/2013-39/ccdr-volume-39-1-november-29-2013.html

3. Joint United Nations Programme on HIV/AIDS. HIV and sex work. [Internet]. Geneva: Joint United Nations Programme on HIV/AIDS; [updated 2021; cited 2022 Jan 04]. Available from: https://www.unaids.org/sites/default/files/media_asset/05-hiv-human-rights-factsheet-sex-work_en.pdf

4. Sax PE. Acute and early HIV infection: Clinical manifestations and diagnosis [Internet]. Gandhi RT, Mitty J, editors. Waltham: UpToDate; [updated 2020; cited 2022 Jan 9]. Available from: https://www.uptodate.com/contents/acute-and-early-hiv-infection-clinical-manifestations-and-diagnosis

5. Carpenter RJ, Bartlett J. Early symptomatic HIV infection [Internet]. Talavera F, John JF, Bartlett J, editors. New York: Medscape; [updated 2021; cited 2022 Jan 9]. Available from: https://reference.medscape.com/article/211873-overview#a1

6. Justiz Vaillant AA, Naik R. HIV-1 associated opportunistic infections [Internet]. StatPearls [Internet]. U.S. National Library of Medicine; 2021 [cited 2022 Jan 9]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK539787/

7. British Columbia Centre for Excellence in HIV/AIDS. Therapeutic Guidelines for Opportunistic Infections. [Internet]. Vancouver: British Columbia Centre for Excellence in HIV/AID; [updated 2009 May; cited 9 Jan 2022]. Available from http://bccfe.ca/therapeutic-guidelines/opportunistic-infection-therapeutic-guidelines

8. DynaMed [Internet]. Ipswich (MA): EBSCO Information Services. 1995 - . Record No. T909352, Latent Tuberculosis Infection in Patients With HIV; [updated 2018 Nov 30, cited 2022 Jan **9**]. Available from https://www.dynamed.com/topics/dmp~AN~T909352 . Registration and login required.

9. Rathee M, Jain P. Hairy leukoplakia [Internet]. StatPearls [Internet]. U.S. National Library of Medicine; 2021 [cited 202 Jan 9]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK554591/

10. Sullivan JL. Clinical manifestations and treatment of Epstein-Barr virus infection [Internet]. Hirsch MS, Kaplan SL, Bond S, editors. Waltham: UpToDate; [updated 2021; cited 2022 Jan 9]. Available from: https://www.uptodate.com/contents/clinical-manifestations-and-treatment-of-epstein-barr-virus-infection

11. Sax PE. Treatment and prevention of Pneumocystis infection in patients with HIV [Internet]. Gandhi RT, Bogorodskaya M, editors. Waltham: UpToDate; [updated 2021; cited 2022 Jan 9]. Available from: https://www.uptodate.com/contents/treatment-and-prevention-of-pneumocystis-infection-in-patients-with-hiv

12. Kauffman CA. Oropharyngeal candidiasis in adults [Internet]. Sexton DJ, Bogorodskaya M, editors. Waltham: UpToDate; [updated 2021; cited 2022 Jan 9]. Available from: https://www.uptodate.com/contents/oropharyngeal-candidiasis-in-adults

13. Groopman JE. AIDS-related Kaposi sarcoma: Staging and treatment [Internet]. Aboulafia DM, Shah S, editors. Waltham: UpToDate; [updated 2021; cited 2022Jan9]. Available from: https://www.uptodate.com/contents/aids-related-kaposi-sarcoma-staging-and-treatment

14. Bishop BN, Lynch DT. Kaposi Sarcoma [Internet]. StatPearls [Internet]. U.S. National Library of Medicine; 2021 [cited 2022 Jan 9]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK534839/

15. Gandhi RT. Toxoplasmosis in patients with HIV [Internet]. Sax PE, Mitty J, editors. Waltham: UpToDate; [updated 2021; cited 2022 Jan 9]. Available from: https://www.uptodate.com/contents/toxoplasmosis-in-patients-with-hiv

16. Ayoade F, Joel Chandranesan AS. HIV-1 associated toxoplasmosis [Internet]. StatPearls [Internet]. U.S. National Library of Medicine; 2021 [cited 2022 Jan 9]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK441877/

17. Sax PE. Screening and diagnostic testing for HIV infection [Internet]. Hirsch MS, Mitty J, editors. Waltham: UpToDate; [updated 2021; cited 2022 Jan 9]. Available from: https://www.uptodate.com/contents/screening-and-diagnostic-testing-for-hiv-infection

18. World Health Organization. Policy brief: consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: what's new. [Internet]. Geneva: World Health Organization; [updated 2015; cited 2022 Jan 9]. Available from: https://apps.who.int/iris/handle/10665/198064.

19. Tan DHS, Hull MW, Yoong D, Tremblay C, O'Byrne P, Thomas R, et al. Canadian guideline on HIV pre-exposure prophylaxis and nonoccupational postexposure prophylaxis. CMAJ. 2017 Nov 27;189(47):E1448–58.

20. Montaner, J, S Guillemi, and M Harris, eds. Therapeutic Guidelines for Antiretroviral (ARV) Treatment of Adult HIV Infection. [Internet]. Vancouver: British Columbia Centre for Excellence in HIV/AIDS; [September 2015; cited 2022 Jan 9]. Available from: http://bccfe.ca/sites/default/files/uploads/Guidelines/bccfe-art-guidelines-Oct_14_2015.pdf.

21. Wolfe C. Immune reconstitution inflammatory syndrome [Internet]. Sax PE, Mitty J, editors. Waltham: UpToDate; [updated 2019; cited 2022 Jan 9]. Available from: https://www.uptodate.com/contents/immune-reconstitution-inflammatory-syndrome

22. Sadiq U, Shrestha U, Guzman N. Prevention of opportunistic infections in HIV/AIDS [Internet]. StatPearls [Internet]. U.S. National Library of Medicine; 2021 [cited 2022 Jan 9]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK513345

23. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV.[Internet]. Washington D.C: Department of Health and Human Services; [updated 2021 Jun 3; cited 2022 Jan 9]. Available from: https://clinicalinfo.hiv.gov/sites/default/files/guidelines/documents/AdultandAdolescentGL.pdf

24. The INSIGHT START Study Group. Initiation of Antiretroviral Therapy in Early Asymptomatic HIV Infection. N Engl J Med. 2015 Aug 27;373(9):795–807.

25. Government of Canada. Immunization of immunocompromised persons: Canadian Immunization Guide. [Internet]. Ottawa: Government of Canada; [updated 2018 May; cited 2022 Jan 9]. Available from: https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-3-vaccination-specific-populations/page-8-immunization-immunocompromised-persons.html

26. DynaMed [Internet]. Ipswich (MA): EBSCO Information Services. 1995 - . Record No. T114653, Prevention of Opportunistic Infections in Patients With HIV; [updated 2019 Aug 7, cited 2022 Jan 9]. Available from https://www.dynamed.com/topics/dmp~AN~T114653. Registration and login required.

27. Sax PE. Overview of prevention of opportunistic infections in patients with HIV [Internet]. Hirsch MS, Bogorodskaya M, editors. Waltham: UpToDate; [updated 2019; cited 2022 Jan 9]. Available from: https://www.uptodate.com/contents/overview-of-prevention-of-opportunistic-infections-in-patients-with-hiv

28. DynaMed [Internet]. Ipswich (MA): EBSCO Information Services. 1995 - . Record No. T901962, Preexposure Prophylaxis (PrEP) for HIV; [updated 2018 Nov 30, cited 2022 Jan 9]. Available from https://www.dynamed.com/topics/dmp~AN~T901962. Registration and login required.

29. Arkell C. [Internet]. Toronto: Canadian AIDS Treatment Information Exchange (CATIE). Pre-exposure prophylaxis (PrEP); [revised 2021; cited 2022 Jan 9]. Available from: https://www.catie.ca/pre-exposure-prophylaxis-prep-0

30. Centers for Disease Control and Prevention (CDC). [Internet]. Atlanta: Centers for Disease Control and Prevention. If I am not at ongoing risk for getting HIV, can I take PrEP only when I'm at risk?; [revised 2021 Dec 10; cited 2022 Jan 9]. Available from: https://www.cdc.gov/hiv/basics/prep/on-demand-prep.html

31. Arkell C. [Internet]. Toronto: Canadian AIDS Treatment Information Exchange (CATIE). Post-exposure prophylaxis (PEP); [revised 2019; cited 2022 Jan 9]. Available from: https://www.catie.ca/fact-sheets/prevention/post-exposure-prophylaxis-pep

32. Camilleri M, Gogolisvili D. [Internet]. Toronto: Ontario HIV Treatment Network. The efficacy of post-exposure prophylaxis (PEP) for HIV; [revised 2019; cited 2022 Jan 9]. Available from: https://www.ohtn.on.ca/rapid-response-the-efficacy-of-post-exposure-prophylaxis-pep-for-hiv/

33. DynaMed [Internet]. Ipswich (MA): EBSCO Information Services. 1995 - . Record No. T191724, Postexposure Prophylaxis (PEP) for HIV; [updated 2018 Nov 30, cited 2022 Jan 9]. Available from https://www.dynamed.com/topics/dmp~AN~T191724. Registration and login required.

34. DynaMed [Internet]. Ipswich (MA): EBSCO Information Services. 1995 - . Record No. T114424, Overview of HIV Infection; [updated 2018 Dec 03, cited 2022 Jan 9]. Available from https://www.dynamed.com/topics/dmp~AN~T114424. Registration and login required.