

Pregnancy Care among Black-African and Black-Caribbean Medically Uninsured People Attending A Toronto Walk-in Clinic: A 10-Year Retrospective Chart Review

Manavi Handa* and Shani Robertson

Toronto Metropolitan University, Toronto, Ontario, Canada

***Corresponding Author**

Manavi Handa, Toronto Metropolitan University, Toronto, Ontario, Canada.

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Abstract

Background: Medically uninsured pregnant people may encounter delayed or fragmented prenatal care because of cost, administrative exclusion, precarious immigration status, lack of a regular primary care provider, housing instability, and fear of healthcare or immigration systems. Canadian evidence about Black medically uninsured pregnant people is limited, and aggregation may obscure important differences among Black populations. This study described Black-African and Black-Caribbean participants attending a low-barrier Toronto pregnancy clinic, examined heterogeneity between these subgroups, and compared selected service-relevant characteristics with other medically uninsured clinic participants.

Methods: We conducted secondary analysis of a retrospective chart review of pregnancy presentations assessed by a midwife at community health centre-based walk-in clinic for medically uninsured people from July 1, 2013, to June 30, 2023. The setting was a clinic intended particularly for uninsured and undocumented Toronto residents without a primary care provider. People holding a current valid visitor, student, or temporary work visa were not eligible for services ("Non-Insured Walk-in Clinic," n.d.). The original cohort comprised 1,170 pregnancy presentations. The three-group analysis included 1,158 presentations: Black-African ($n = 114$), Black-Caribbean ($n = 119$), and all-other medically uninsured participants ($n = 925$). Twelve Black participants from other regions were excluded from subgroup comparison because data cells were too small for meaningful interpretation. Analyses used variable-specific denominators, 95% confidence intervals, and overall three-group p values.

Results: Mean gestational age at first presentation was 22.12 weeks among Black-African participants, 17.61 weeks among Black-Caribbean participants, and 14.71 weeks among all-other participants. Third-trimester presentation occurred in 45.5%, 22.7%, and 17.8%, respectively. Black-African participants were more likely to report previous prenatal care overseas (44.2% vs. 12.4% Black-Caribbean and 14.3% all-other), yet 57.8% of those with prior care lacked records, compared with 34.3% and 35.6% respectively. Anemia was documented in 13.2% of Black-African, 15.1% of Black-Caribbean, and 4.8% of all-other participants. Risk classification and referral destination did not differ significantly across groups.

Conclusions: Black-African and Black-Caribbean participants were not interchangeable populations. The most pronounced inequities occurred before entry to the clinic. Black-African participants presented latest and had the highest observed proportion of absent records among participants with previous prenatal care. Both Black subgroups had more documented anemia than all-other participants. Similar risk classification and referral destinations after assessment do not establish an effect of midwifery care, but the largest observed group differences occurred before participants reached the clinic. Findings support earlier outreach, patient navigation, proactive provision of patient-held prenatal records, rapid anemia assessment and treatment, and accessible pathways into ongoing care.

1. Background

Human mobility is a defining global public-health issue. At the end of 2025, approximately 117.8 million people were forcibly displaced worldwide, including 41.6 million refugees and 9.0 million asylum seekers (United Nations High Commissioner for Refugees, 2026). These figures capture forced displacement rather than all international migration and substantially undercount people living with irregular or undocumented status. Migration and displacement are expected to remain high because of conflict, political and economic insecurity and climate-related disasters. The World Health Organization identifies refugee and migrant health as both a global health priority and a human-rights obligation, emphasizing that poorer outcomes arise not from migration itself but from restrictive policies, institutional discrimination, precarious living conditions, and exclusion from affordable services [1].

For high-migrant receiving countries, access to pregnancy care is therefore both a public-health responsibility and a humanitarian concern. Pregnancy continues regardless of insurance or immigration eligibility, and excluding people from timely preventive care does not remove their need for care; it shifts assessment and treatment later in pregnancy and often toward emergency or urgent hospital settings [2-4]. Pregnant migrants may carry the cumulative effects of interrupted care, hazardous journeys, gender-based violence, unstable housing and employment, family separation, and fear of authorities or deportation [5-9]. Health systems in receiving countries must respond to these realities through inclusive, confidential, low-barrier pathways that connect community-based assessment with ongoing prenatal care and hospital-based assessment when necessary. The midwife-led program through this community health centre based clinic offers an example of such a response within a high-migration urban setting.

Early and regular prenatal care creates opportunities to confirm gestational age, identify medical and social needs, complete time-sensitive screening, initiate supplementation and treatment, and arrange appropriate follow-up [10-12]. Canadian guidance describes an initial visit ideally within the first trimester and recognizes that equitable access requires community- and population-based approaches [13,14]. Inadequate or delayed prenatal care has been associated with adverse pregnancy outcomes, although care adequacy also reflects underlying social and clinical conditions [10,15]. Presentation at a mean gestational age of 18 or 22 weeks therefore represents a clinically meaningful compression of the first-trimester assessment and screening period, rather than merely a difference in visit timing.

Like other similar high-income, high-migrant receiving countries, Canada's publicly financed healthcare system does not provide uniform practical access to everyone living in the country [16-20]. Medically uninsured residents include people without immigration status, people with precarious or changing status, and others who do not meet provincial or federal eligibility rules. Cost, uncertainty about eligibility, administrative requirements, fear of immigration consequences, lack of a regular primary care provider, repeated

reliance on walk-in services, and difficulty locating a willing provider can delay or fragment pregnancy care [16,21,4,12]. Missing prenatal records is especially important in this setting. When laboratory and ultrasound results, screening history, and prior obstetric documentation do not travel with the patient, clinicians may need to repeat investigations, make decisions with incomplete information, or delay referral while records are sought. Record discontinuity may reflect care dispersed across multiple providers, clinics, countries, or acute-care encounters. It may also reflect unequal control over health information: patients may not be offered copies, may not know that they can request them, or may not feel entitled or safe enough to do so. Housing instability can make paper records difficult to retain, while some people may avoid carrying documents that disclose pregnancy when travelling across borders. The present dataset cannot determine which, if any, of these mechanisms occurred.

Black populations in Canada are large and heterogeneous. In 2021, 1.5 million people identified as Black, representing 4.3% of Canada's population; more than four in ten were born in Canada [22-24]. In the Toronto census metropolitan area, 442,015 people identified as Black in 2016, representing 7.5% of the population [23]. These population figures cannot be converted into an estimate of Black medically uninsured pregnant people: no reliable Toronto, Ontario, or Canadian denominator identifies the intersection of Black identity, pregnancy, and medical uninsurance. This absence is itself an important surveillance gap.

Canadian population-based and qualitative research has documented Black perinatal inequities and experiences of obstetric racism, including dismissal, dehumanization, and reduced trust [6,25-27]. Race is therefore treated here as a socially produced marker of differential exposure to racism and other structural conditions, not as a biological risk factor. Black-African and Black-Caribbean populations may differ in immigration pathways, language, household structure, settlement history, and interaction with health systems. Disaggregation is necessary when the data permit it [28].

This study aimed to (1) describe the sociodemographic, access, prenatal-care, reproductive-history, and clinical characteristics of Black-African and Black-Caribbean medically uninsured pregnancy presentations; (2) examine descriptive heterogeneity between these subgroups; and (3) compare selected clinically actionable and service-relevant outcomes with the 925 non-Black medically uninsured presentations from the same clinic. All comparisons are interpreted as differences within a structurally marginalized uninsured cohort, not as causal effects of race, immigration or clinic care.

2. Methods

2.1. Design and Reporting

This was a secondary analysis of a retrospective descriptive chart review of routinely collected intake and clinical information. Reporting was informed by the STROBE statement and the RECORD extension for routinely collected health data (Benchimol

et al., 2015; von Elm et al., 2007). Because all eligible records from the 10-year period were reviewed, no sample-size calculation was performed. There was no linkage to hospital, birth-registry, or provincial administrative data on pregnancy and neonatal outcomes.

2.2. Setting and Care Model

The walk-in clinic for non-insured people was within a larger Toronto-based community health centre. In response to growing community need, the clinic was established in 2012 as a confidential, no-charge access point particularly for uninsured and undocumented immigrants and refugees living in Toronto. Eligibility required absence of current public or private health coverage and absence of a regular primary care provider. People holding a current valid visitor visa, student visa, or temporary work visa were not eligible. The midwife-led pregnancy service operated within a nurse-practitioner-led community health centre clinic. All pregnant patients were assessed by a midwife in an episodic, non-continuity walk-in model. The visits focused on history, examination, initial investigations, stabilization where needed and eventual referral for to ongoing prenatal care with either a midwife or obstetrician. The clinic midwife was affiliated with a community midwifery practice and held privileges at two hospitals, which supported referral to midwifery, obstetrics, early-pregnancy, diabetes, and other hospital-based services as needed. These organizational features describe the pathway available after presentation; this study did not compare professional models of care and cannot estimate a causal effect of midwifery assessment (Access Alliance Multicultural Health and Community Services,

2025, 2026).

2.3. Participants and Analytic Groups

The original search identified 1,324 pregnancy-related records. Investigators removed 124 duplicate records, 21 records with no or minimal documentation, and 9 newborn records, leaving 1,170 eligible pregnancy presentations. The duplicate records were duplicate charts or records identified during data cleaning; they were not analyzed as repeat pregnancies. Because the dataset was de-identified, separate pregnancies experienced by the same person could not be linked. The analytic unit is therefore the eligible pregnancy presentation, and possible non-independence of repeat pregnancies is a limitation.

Race/ethnicity and country or region of origin were self-reported on clinic intake forms. Participants were classified as Black-African or Black-Caribbean when both Black identity and African or Caribbean origin were documented. Of 245 Black participants, 114 were classified as Black-African and 119 as Black-Caribbean. Twelve Black participants from other regions (Europe, n = 5; North America, n = 4; Middle East, n = 2; Central America, n = 1) were excluded from the three-group subgroup comparison because the cells were too small for meaningful interpretation. The all-other comparator comprised 925 medically uninsured participants, including 471 who self-identified as Latin American and 454 in other racial/ethnic categories. The final three-group analytic cohort therefore included 1,158 pregnancy presentations. The comparator supplies context within the same clinic rather than a normative or insured reference group.

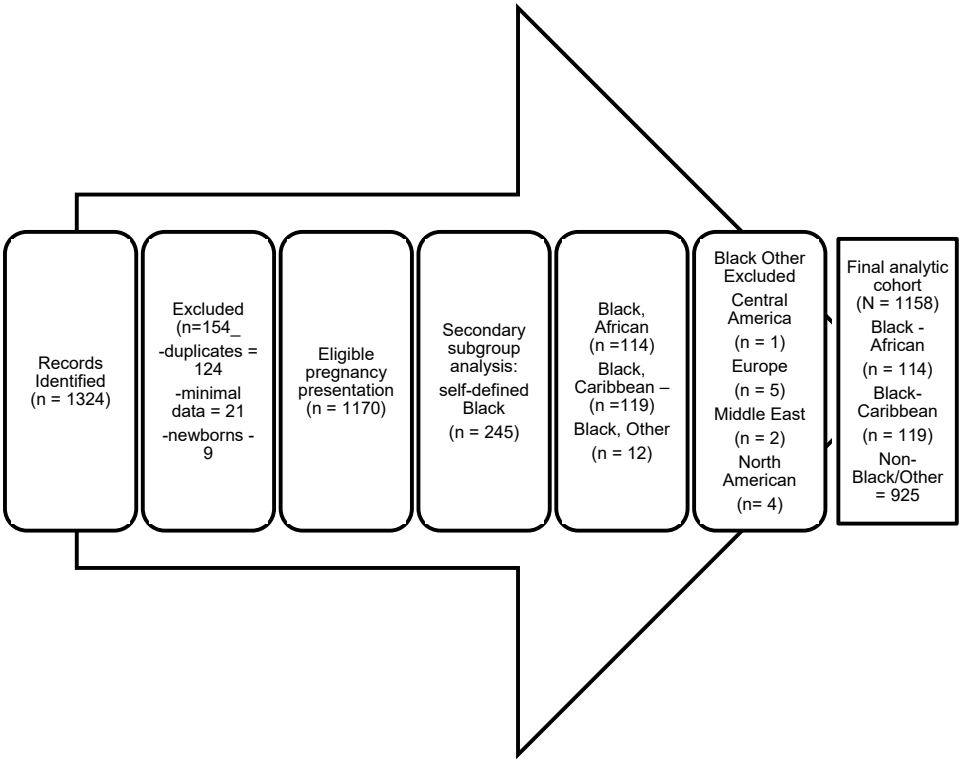


Figure 1: Participant Flow Diagram

2.4. Data sources, Variables, and Outcome Selection

Clinical and pregnancy variables were abstracted from electronic medical records. Sociodemographic, racial/ethnic and access variables were obtained from patient-completed registration forms. Forms changed during the study period and were not uniformly complete. Variables were grouped into demographics; access; prenatal timing and continuity; reproductive and obstetric history; pregnancy comorbidities and complications; risk status; and referral trajectory.

Outcomes were selected a priori for this secondary analysis based on clinical relevance, service-planning applicability and consistent availability of data in the clinical record. Outcomes included third-trimester presentation, prior prenatal care, prenatal-record availability among those with prior care, interpreter requirement, anemia, pregnancy risk designation, referral destination, urgent emergency department or labour-and-delivery referral, and documented loss to follow-up. Birth outcomes were not selected because the clinic record was not linked to delivery records.

Prenatal-record availability was conditional on previous prenatal care and indicated whether records from that care were available at the uninsured clinic assessment. It was selected because the ability to carry clinical information across providers and jurisdictions is a distinct dimension of continuity: care may have occurred without the resulting information being available for subsequent decisions. The variable does not explain why records were absent. Anemia was defined as a charted diagnosis or hemoglobin below 105 g/L; trimester-based cut-offs were not used. High-risk designation reflected documented need for ongoing obstetric involvement based on clinical assessment and applicable Ontario midwifery consultation guidelines [29]. Additionally, participants who had two or more previous cesarean sections, had a current multiple gestation or breech at term were also classified as high risk because of local hospital standards.

2.5. Statistical Analysis

Analyses used variable-specific denominators. Continuous variables are reported as mean $\pm$ standard deviation (SD), with 95% confidence intervals (CIs) for the mean calculated using the Student t distribution. Categorical variables are reported as n/N (%) with 95% Wald CIs for proportions. For categorical variables with more than two response categories, each displayed category was coded as present versus all other categories and analyzed in a separate 3 $\times$ 2 table. Accordingly, categorical p values are row-specific three-group comparisons and are not global omnibus tests of the complete multicategory variable. Pearson chi-square tests were used when all expected cell counts were at least 5, and Fisher–Freeman–Halton exact tests were used when any expected cell count was less than 5. Three-group comparisons of continuous

variables used one-way analysis of variance for normally distributed variables or Kruskal–Wallis tests for skewed variables, as appropriate. No post-hoc pairwise comparisons were conducted. Because the analyses were descriptive and no adjustment was made for multiple comparisons, individual p values should be interpreted cautiously and do not infer causality. Analyses were conducted using IBM SPSS Statistics, version 31.0.

2.6. Missing Data

No imputation was performed. Variable specific denominator are shown in individual cells or rows. Conditional variables use eligible denominators rather than the full cohort. Intake-form changes and incomplete patient responses produced greater missingness for socioeconomic than clinical variables.

2.7. Ethics

Ethics approval was obtained from the University of Toronto Research Ethics Board (REB 2022-064) and Toronto Metropolitan University Research Ethics Board (2022-064-4). The requirement for individual consent was waived for this retrospective, de-identified chart review.

3. Results

3.1. Cohort Composition and Demographic Context

Mean age differed statistically ($p = 0.002$), although the absolute differences were small; 30.37 years among Black-African participants, 31.56 years among Black-Caribbean participants, and 29.63 years among all-other participants. Relationship status and education showed substantial heterogeneity. Common-law or married status was reported by 71.6% of Black-African, 34.6% of Black-Caribbean, and 72.1% of all-other participants ($p < .001$). Conversely, 57.0% of Black-Caribbean participants were single compared with 20.6% of Black-African and 19.6% of all-other participants ($p < .001$). Secondary education was most common among Black-Caribbean participants (61.8%), while post-secondary education was more common among Black-African (57.1%) and all-other participants (57.4%; both $p < .001$).

With respect to income, among participants providing an income, the proportion below \$30,000 is approximately 83.7%, 97.8%, and 82.8% ($p = 0.014$). Household context also differed. Black-African and Black-Caribbean respondents supported more people with their income than all-other respondents (means 2.91, 2.77, and 2.22; $p < .001$). Black-African participants more often lived as a couple with children (40.2%), whereas Black-Caribbean participants more often lived with extended family or siblings (25.5%) or unrelated housemates (13.8%). Income results require caution because “do not know” and “prefer not to answer” were common response categories.

Characteristic	Black-African (n = 114)	Black-Caribbean (n = 119)	All-Other (n = 925)	Three-group p value
Age, years, M ± SD	30.37 ± 4.83 [29.47, 31.26]	31.56 ± 5.94 [30.49, 32.64]	29.63 ± 5.88 [29.25, 30.01]	0.002
Relationship status				
Common-law/married	73/102 (71.6) [62.8, 80.3]	37/107 (34.6) [25.6, 43.6]	481/667 (72.1) [68.7, 75.5]	<0.001
Single	21/102 (20.6) [12.7, 28.4]	61/107 (57.0) [47.6, 66.4]	131/667 (19.6) [16.6, 22.7]	<0.001
Separated/divorced/ widowed	2/102 (2.0) [0.0, 4.7]	3/107 (2.8) [0.0, 5.9]	15/667 (2.2) [1.1, 3.4]	0.924
Do not know	6/102 (5.9) [1.3, 10.4]	6/107 (5.6) [1.2, 10.0]	40/667 (6.0) [4.2, 7.8]	0.987
Highest education				
No formal education	4/98 (4.1) [0.2, 8.0]	0/110 (0.0)	12/740 (1.6) [0.7, 2.5]	0.077
Primary school	5/98 (5.1) [0.7, 9.5]	5/110 (4.5) [0.7, 8.4]	35/740 (4.7) [3.2, 6.3]	0.963
Secondary or equivalent	33/98 (33.7) [24.3, 43.0]	68/110 (61.8) [52.7, 70.9]	268/740 (36.2) [32.8, 39.7]	<0.001
Post-secondary education	56/98 (57.1) [47.3, 66.9]	37/110 (33.6) [24.8, 42.5]	425/740 (57.4) [53.9, 61.0]	<0.001
Annual household income (CAD)				
< 30,000	36/111 (32.4) [23.7, 41.1]	45/115 (39.1) [30.2, 48.1]	275/891 (30.9) [27.8, 33.9]	0.200
30,000 - 59,999	7/111 (6.3) [1.8, 10.8]	0/115 (0.0)	50/891 (5.6) [4.1, 7.1]	0.030
≥ 60,000	0/111 (0.0)	1/115 (0.9) [0.0, 2.6]	7/891 (0.8) [0.2, 1.4]	1.00
"Do not know" income response	47/111 (42.3) [33.2, 51.5]	43/115 (37.4) [28.5, 46.2]	391/891 (43.9) [40.6, 47.1]	0.411
Prefer not to answer	21/111 (18.9) [11.6, 26.2]	26/115 (22.6) [15.0, 30.3]	168/891 (18.9) [16.3, 21.4]	0.628
Number supported by income, M ± SD	2.91 ± 1.92 [2.38, 3.44]	2.77 ± 1.49 [2.37, 3.17]	2.22 ± 1.08 [2.13, 2.31]	<0.001
Household composition				
Single	21/87 (24.1) [15.1, 33.1]	14/94 (14.9) [7.7, 22.1]	79/757 (10.4) [8.3, 12.6]	<0.001
Couple without child	16/87 (18.4) [10.3, 26.5]	13/94 (13.8) [6.9, 20.8]	317/757 (41.9) [38.4, 45.4]	<0.001
Couple with children	35/87 (40.2) [29.9, 50.5]	20/94 (21.3) [13.0, 29.6]	206/757 (27.2) [24.0, 30.4]	0.012
Extended family/siblings	3/87 (3.4) [0.0, 7.3]	24/94 (25.5) [16.7, 34.3]	47/757 (6.2) [4.5, 7.9]	<0.001
Unrelated housemates	6/87 (6.9) [1.6, 12.2]	13/94 (13.8) [6.9, 20.8]	33/757 (4.4) [2.9, 5.8]	0.002
Prefer not to answer	6/87 (6.9) [1.6, 12.2]	10/94 (10.6) [4.4, 16.9]	75/757 (9.9) [7.8, 12.0]	0.634
Distance from clinic				
≤10 km	61/114 (53.5) [44.4, 62.7]	69/118 (58.5) [49.6, 67.4]	565/919 (61.5) [58.3, 64.6]	0.235
10.1-20 km	30/114 (26.3) [18.2, 34.4]	35/118 (29.7) [21.4, 37.9]	216/919 (23.5) [20.8, 26.2]	0.302

>20 km	23/114 (20.2) [12.8, 27.5]	14/118 (11.9) [6.0, 17.7]	138/919 (15.0) [12.7, 17.3]	0.199
Transit time				
≤30 minutes	35/114 (30.7) [22.2, 39.2]	53/118 (44.9) [35.9, 53.9]	285/919 (31.0) [28.0, 34.0]	0.009
31 - 60 minutes	51/114 (44.7) [35.6, 53.9]	48/118 (40.7) [31.8, 49.5]	450/919 (49.0) [45.7, 52.2]	0.190
>60 minutes	28/114 (24.6) [16.7, 32.5]	17/118 (14.4) [8.1, 20.7]	184/919 (20.0) [17.4, 22.6]	0.150
English as home language	87/114 (76.3) [68.5, 84.1]	117/119 (98.3) [96.0, 100.0]	67/915 (7.3) [5.6, 9.0]	<0.001
Interpreter required				
Yes	14/114 (12.3) [6.3, 18.3]	2/119 (1.7) [0.0, 4.0]	570/920 (62.0) [58.8, 65.1]	<0.001
No	100/114 (87.7) [81.7, 93.7]	117/119 (98.3) [96.0, 100.0]	350/920 (38.0) [34.9, 41.2]	<0.001
Note: Values are M ± SD [95% CI] or n/N (%) [95% CI]. Overall p values compare Black-African, Black-Caribbean, and all-other groups. Variable-specific denominators reflect missing data and valid “do not know” or “prefer not to answer” responses. CAD = Canadian dollars; CI = confidence interval; M = mean; SD = standard deviation.				

Table 1: Demographic and Access Characteristics among Black-African, Black-Caribbean, and all-other Medically Uninsured Pregnancy Presentations

3.2. Access Characteristics

Distance from the clinic did not differ significantly across groups. Public transit time of 30 minutes or less was reported by 30.7% of Black-African, 44.9% of Black-Caribbean, and 31.0% of all-other participants ($p = .009$). English as the home language was documented for 76.3% of Black-African and 98.3% of Black-Caribbean participants, compared with 7.3% of all-other participants ($p < .001$). Interpreter need showed the inverse pattern: 12.3%, 1.7%, and 62.0%, respectively ($p < .001$). These group-level patterns suggest that measured interpreter need alone is unlikely to explain the timing of presentation different; individual level associations were not tested.

3.3. Prenatal Timing and Documentation Continuity

Gestational age at first presentation differed across all three groups ($p < .001$). Black-African participants presented at a mean of 22.12 weeks, compared with 17.61 weeks among Black-Caribbean

and 14.71 weeks among all-other participants. First-trimester presentation occurred in 30.9%, 42.7%, and 59.7%, respectively ($p < .001$), while third-trimester presentation occurred in 45.5%, 22.7%, and 17.8% ($p < .001$).

Previous-care pathways also differed. No previous prenatal care was documented for 43.4% of Black-African participants, compared with 69.0% of Black-Caribbean and 70.9% of all-other participants ($p < .001$). Overseas prenatal care was documented for 44.2% of Black-African participants, compared with 12.4% of Black-Caribbean and 14.3% of all-other participants ($p < .001$). Despite this greater prior-care exposure, records were absent for 57.8% of Black-African participants with prior care, compared with 34.3% of Black-Caribbean and 35.6% of all-other participants ($p = .004$). This pattern identifies documentation continuity as distinct from whether care occurred.

Characteristic	Black-African (n = 114)	Black-Caribbean (n = 119)	All-Other (n = 925)	Three-group p value
Gestational age at first presentation, weeks, M ± SD	22.12 ± 11.16 [20.01, 24.23]	17.61 ± 10.07 [15.71, 19.51]	14.71 ± 9.89 [14.05, 15.38]	<0.001
Gestational age at first presentation				
First trimester (0-13 weeks)	34/110 (30.9) [22.3, 39.5]	47/110 (42.7) [33.5, 52.0]	511/856 (59.7) [56.4, 63.0]	<0.001
Second trimester (14 - 26 weeks)	26/110 (23.6) [15.7, 31.6]	38/110 (34.5) [25.7, 43.4]	193/856 (22.5) [19.7, 25.3]	0.021
Third trimester (≥27 weeks)	50/110 (45.5) [36.1, 54.8]	25/110 (22.7) [14.9, 30.6]	152/856 (17.8) [15.2, 20.3]	<0.001

Prior prenatal care				
No prior prenatal care	49/113 (43.4) [34.2, 52.5]	78/113 (69.0) [60.5, 77.6]	637/899 (70.9) [67.9, 73.8]	<0.001
Prior prenatal care in Canada	14/113 (12.4) [6.3, 18.5]	21/113 (18.6) [11.4, 25.8]	133/899 (14.8) [12.5, 17.1]	0.412
Prior prenatal care overseas	50/113 (44.2) [35.1, 53.4]	14/113 (12.4) [6.3, 18.5]	129/899 (14.3) [12.1, 16.6]	<0.001
Absent prenatal records among those with prior care	37/64 (57.8) [45.7, 69.9]	12/35 (34.3) [18.6, 50.0]	93/261 (35.6) [29.8, 41.4]	0.004
Note: Values are M ± SD [95% CI] or n/N (%) [95% CI]. Prenatal-record absence uses the conditional denominator of participants with documented prior prenatal care. CI = confidence interval; M = mean; SD = standard deviation.				

Table 2: Prenatal Timing, Prior Prenatal Care, and Prenatal-Record Availability

3.4. Reproductive History, Clinical needs, and Referral

Black-African and Black-Caribbean participants had higher mean gravidity and numbers of term births than all-other participants (both $p < .001$). Previous cesarean birth among those with previous birth history was less frequent in Black-African (35.9%) and Black-Caribbean participants (32.3%) than in all-other participants (55.5%; $p < .001$).

Anemia was significantly more common in the two Black subgroups: 13.2% and 15.1%, compared with 4.8% among all-other participants ($p < .001$). Urinary tract infection was less common among Black-African (5.3%) and Black-Caribbean participants (5.9%) than among all-other participants (13.1%; $p = .006$). Diabetes, hypertension, sexually transmitted or blood-borne infection and pregnancy loss did not differ significantly.

Additional exploratory, unadjusted differences were observed. Previous neonatal death or stillbirth was documented in 5.3% of Black-African, 2.5% of Black-Caribbean, and 1.1% of all-other participants ($p = .005$). Nausea and vomiting of pregnancy was documented in 6.1%, 16.8%, and 12.8%, respectively ($p = .043$), and bleeding in 1.8%, 9.2%, and 9.2%, respectively ($p = .025$).

High-risk pregnancy classification did not differ significantly across groups: 27.6% among Black-African, 22.9% among Black-Caribbean, and 20.3% among all-other participants ($p = .206$). Referral destination was also similar. Approximately three quarters of each group were referred to midwifery care, and 16% to 20% were referred to obstetrics. Urgent emergency department or labour-and-delivery referral and documented loss to follow-up were uncommon and did not differ significantly. These results describe recorded decisions after clinic assessment; they do not demonstrate that midwifery care caused lower emergency use.

Characteristic	Black-African (n = 114)	Black-Caribbean (n = 119)	All-Other (n = 925)	Three-group p value
Gravida, M ± SD	2.52 ± 1.41 [2.26, 2.79]	2.79 ± 1.86 [2.44, 3.13]	1.91 ± 1.13 [1.84, 1.99]	<0.001
Term births, M ± SD	0.92 ± 0.97 [0.74, 1.10]	1.09 ± 1.43 [0.82, 1.36]	0.49 ± 0.80 [0.43, 0.54]	<0.001
Preterm birth history	7/114 (6.1) [1.7, 10.5]	9/119 (7.6) [2.8, 12.3]	47/925 (5.1) [3.7, 6.5]	0.554
Previous neonatal death or stillbirth	6/114 (5.3) [1.2, 9.4]	3/119 (2.5) [0.0, 5.3]	10/925 (1.1) [0.4, 1.7]	0.501
Previous caesarean among those with previous birth history	23/64 (35.9) [24.2, 47.7]	21/65 (32.3) [20.9, 43.7]	183/330 (55.5) [50.1, 60.8]	<0.001
Condition or complication				
Anemia	15/114 (13.2) [7.0, 19.4]	18/119 (15.1) [8.7, 21.6]	44/925 (4.8) [3.4, 6.1]	<0.001
Diabetes	4/114 (3.5) [0.1, 6.9]	8/119 (6.7) [2.2, 11.2]	33/925 (3.6) [2.4, 4.8]	0.240
Hypertension	4/114 (3.5) [0.1, 6.9]	9/119 (7.6) [2.8, 12.3]	30/925 (3.2) [2.1, 4.4]	0.075
Other medical conditions	22/114 (19.3) [12.1, 26.5]	13/119 (10.9) [5.3, 16.5]	179/925 (19.4) [16.8, 21.9]	0.081

Urinary tract infection	6/114 (5.3) [1.2, 9.4]	7/119 (5.9) [1.7, 10.1]	121/925 (13.1) [10.9, 15.3]	0.006
Sexually transmitted or blood-borne infection	7/114 (6.1) [1.7, 10.5]	6/119 (5.0) [1.1, 9.0]	55/925 (5.9) [4.4, 7.5]	0.917
Nausea and vomiting of pregnancy	7/114 (6.1) [1.7, 10.5]	20/119 (16.8) [10.1, 23.5]	118/925 (12.8) [10.6, 14.9]	0.043
Bleeding	2/114 (1.8) [0.0, 4.2]	11/119 (9.2) [4.0, 14.4]	85/925 (9.2) [7.3, 11.1]	0.025
Pregnancy loss	6/114 (5.3) [1.2, 9.4]	8/119 (6.7) [2.2, 11.2]	78/925 (8.4) [6.6, 10.2]	0.435
Pregnancy risk status				
Low-risk pregnancy status	76/105 (72.4) [63.8, 80.9]	84/109 (77.1) [69.2, 85.0]	644/808 (79.7) [76.9, 82.5]	0.206
High-risk pregnancy status	29/105 (27.6) [19.1, 36.2]	25/109 (22.9) [15.0, 30.8]	164/808 (20.3) [17.5, 23.1]	0.206
Referral Destination among those with continued pregnancies				
Midwife	76/104 (73.1) [64.6, 81.6]	80/109 (73.4) [65.1, 81.7]	600/800 (75.0) [72.0, 78.0]	0.870
Obstetrician	19/104 (18.3) [10.8, 25.7]	22/109 (20.2) [12.6, 27.7]	130/800 (16.3) [13.7, 18.8]	0.544
Midwife and Obstetrician	3/104 (2.9) [0.0, 6.1]	3/109 (2.8) [0.0, 5.8]	14/800 (1.8) [0.8, 2.7]	0.486
Urgent emergency department or labour and delivery triage	1/104 (1.0) [0.0, 2.8]	1/109 (0.9) [0.0, 2.7]	14/800 (1.8) [0.8, 2.7]	1.00
Lost to follow up	4/104 (3.8) [0.2, 7.5]	0/109 (0.0)	18/800 (2.3) [1.2, 3.3]	0.101
Note: Values are M ± SD [95% CI] or n/N (%) [95% CI]. Previous cesarean birth, external skin-incision designation, risk status, and referral destination use conditional or variable-specific denominators.. CI = confidence interval; M = mean; SD = standard deviation.				

Table 3: Reproductive History, Clinical needs, Pregnancy Risk, and Referral Destination

4. Discussion

This 10-year review demonstrates why Black medically uninsured pregnant people should not be treated as a single homogeneous group. Black-African and Black-Caribbean participants differed markedly in relationship status, education, household composition, home language, interpreter need, prior-care pathway, and timing of presentation. The ‘all other’ non-Black comparator was not an insured or socially advantaged reference population; it comprised other medically uninsured clinic participants.

The most consequential access pattern was concentrated among Black-African participants. They were more likely to have received prenatal care overseas than either Black-Caribbean or all-other participants, yet they presented latest and were most likely to arrive without records after previous care. Both Black subgroups also had substantially more documented anemia than all-other participants. Pregnancy risk classification and referral destination were similar across groups once participants reached the clinic.

Canadian clinical guidance, and international standards in high-resource settings, recommend that the initial pregnancy visit occur

in the first trimester [13,14]. Mean presentation at 22.12 weeks among Black-African participants occurred approximately 10 to 16 weeks beyond that window, and 45.5% first presented in the third trimester. This timing can compress or eliminate opportunities for first-trimester aneuploidy screening, early infectious-disease and anemia assessment, accurate dating, prevention counselling, and timely referral. The finding is consistent with Canadian studies describing late or disrupted care among uninsured and undocumented pregnant people [3,12,30].

The lower observed proportions of nausea and vomiting and bleeding among Black-African participants may partly reflect their later gestational age at presentation, because symptoms occurring earlier in pregnancy may have resolved or may not have been recorded by the time of assessment; these findings should therefore not be interpreted as indicating lower occurrence throughout pregnancy. This timing explanation does not apply to previous neonatal death or stillbirth, which reflects obstetric history and was descriptively highest among Black-African participants; however, the small number of events and the unadjusted, row-specific comparison warrant cautious interpretation.

Low interpreter requirement among Black participants does not mean communication was irrelevant. It does indicate that an explanation centred only on translation is inadequate. In the available subgroup data, English was reported at home by nearly all Black-Caribbean and most Black-African participants. Later presentation may therefore be more consistent with cost, eligibility uncertainty, fear of billing or immigration consequences, difficulty locating care, poor prior experiences or reduced trust. These unmeasured mechanisms are hypotheses that warrant further investigation.

Among participants reporting income, financial strain may have been particularly acute for Black-Caribbean participants: 97.8% reported annual incomes below \$30,000 while supporting an average of 2.77 people. This combination of very low income and substantial household responsibility may indicate heightened economic precarity, although interpretation is limited by income non-response and the absence of pairwise post-hoc comparisons.

Previous prenatal care and usable prenatal documentation are distinct dimensions of access. A person may have obtained care elsewhere yet arrive without screening or operative information. The Black-African pattern is especially interesting: participants more often reported previous prenatal care, much of it overseas, yet were less likely than Black-Caribbean participants with prior care to have records available. The dataset cannot explain this pattern. Plausible mechanisms include records not being offered; patients not knowing that they can ask for copies or not feeling entitled to do so; care dispersed across multiple providers; loss of documents during housing instability; and reluctance to carry records that identify a pregnancy while crossing borders. These possibilities should be framed as hypotheses, not findings. Regardless of mechanism, unavailable laboratory, ultrasound, screening, and operative information can lead to repeated testing, uncertainty about gestational dating or previous cesarean details, delayed risk stratification, and avoidable acute-care use. The result therefore identifies an important and modifiable action point: providers caring for people who may move between services or jurisdictions should routinely offer prenatal records rather than relying on patients to request them.

Anemia was documented in 13.2% of Black-African and 15.1% of Black-Caribbean participants, compared with 4.8% of all-other participants. This is an actionable clinical signal. Delayed testing, limited access to iron rich foods or supplements, food insecurity, and other unmeasured structural factors may all be contributing factors.

The findings support several additional service changes. Outreach should clearly state eligibility criteria and that confidential prenatal assessment is available without fear of immigration related consequences. Messages should be distributed through trusted Black-led and Black-serving newcomer, faith, settlement, shelter, legal, food-security, and community organizations. Peer health workers and community ambassadors could provide earlier navigation. Navigation should begin before the clinic visit, with

clear information about confidentiality, cost, documentation requirements, referral options, and the limits of information sharing.

At the clinical level, later presentation warrants a streamlined late-entry pathway that bundles gestational dating, core laboratory testing, anemia assessment and rapid treatment, time-sensitive screening discussion, medication review, records retrieval, and referral. Every provider caring for a patient who may move between services should offer—not merely wait to be asked for—a patient-held prenatal package containing the prenatal record, laboratory and ultrasound reports, medication list, blood group, estimated due date, major risk factors, previous cesarean information, and referral contacts. Copies should be available on paper and, where safe and desired, electronically; providers should discuss how to store or carry records safely when housing or immigration circumstances are precarious. Consent-based record retrieval, translation support, and a named navigation contact could reduce information loss between international, community, emergency, hospital, and midwifery settings.

The clinical implications also extend to health-system costs. Delayed or inadequate prenatal care is associated with missed opportunities to identify and respond to risks for preterm birth and low birth weight; this study did not include linked birth outcomes and therefore cannot determine whether delayed clinic presentation caused either outcome. The concern is nevertheless important because Ontario population data already demonstrate higher adjusted risks of preterm birth and low birth weight among Black pregnant people compared with White pregnant people [27]. Canadian neonatal intensive-care studies also show that prematurity generates substantial inpatient expenditure: median tertiary-NICU cost was approximately \$20,184 for preterm infants overall, while costs for extremely preterm infants were considerably higher and increased with intensity and duration of care [31-36].

4.1. Strengths and Limitations

Strengths include a 10-year review of eligible presentations at a long-running low-barrier clinic, inclusion of 925 other medically uninsured participants as a contextual comparator, disaggregation of Black-African and Black-Caribbean participants, and presentation of group-specific estimates with 95% confidence intervals. The three-group tables make visible both within-Black heterogeneity and differences relative to others experiencing medical uninsurance.

The study is a retrospective review from one urban clinic and largely reflects assessments by one midwife; it cannot represent people who never reached care. The design cannot determine causation or compare midwifery with obstetric, family-medicine, or nurse-practitioner care. Referral records do not establish downstream service use or birth outcomes. Intake forms changed, and no imputation, multivariable adjustment, or post-hoc pairwise analysis was conducted. Self-reported identity was constrained by the clinic form. The de-identified data could not link repeat pregnancies, so observations may not be fully independent.

Racism, discrimination, fear, trust, food insecurity, and patient experience were not measured directly.

Conclusion

Black-African and Black-Caribbean medically uninsured pregnancy presentations at this urban Toronto clinic differed substantially in social context, household composition, language, and prenatal-care trajectory. Black-African participants presented latest and were most likely to lack records despite previous overseas care, while both Black subgroups had more documented anemia than all-other participants. The coexistence of prior care and absent documentation among Black-African participants warrants particular attention. Although its cause is unknown, it supports a practice standard in which providers proactively give patients copies of essential prenatal information and facilitate consent-based transfer across providers and jurisdictions. Similar risk classification and referral destinations after clinic assessment locate the largest observed differences upstream of referral but do not establish a causal benefit of midwifery care. Findings support earlier outreach, navigation, portable documentation, rapid late-entry assessment, anemia treatment, and anti-racist, Black-centered service design. Future linked, qualitative, and prospective research should measure birth outcomes and patient-reported experiences of racism and access.

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