Introducing the relaunch of the Stop TB Canada newsletter

Stop TB Canada is a national partner of the global Stop TB Initiative. Globally, Stop TB was created over a decade ago to ensure that everyone vulnerable to TB is being served and has access to high-quality treatment. Stop TB Canada was founded in February 2001 to bring together academics, government, NGOs, community engagement groups, and many others to ensure Canada is adhering to its commitments to reduce TB in our own country and assist in TB efforts on a global scale.

In addition to our community engagement efforts, Stop TB Canada has led Canadian World TB Day events in Ottawa and Vancouver, and hosts an annual Stop TB Day at the North American Region meeting of the International Union Against Tuberculosis and Lung Disease. Recently, the Stop TB Canada Executive Committee made a commitment to create a forum for Canadians interested in all aspects of tuberculosis. We are therefore relaunching this newsletter, originally began in 2003. The newsletter will be distributed on a quarterly basis via email, as a way of ensuring Canada's TB community is aware of not only Stop TB Canada's activities, but also kept abreast of Canadian research activity, national and international conferences, and issues of interest around national and global engagement.

In this issue, we feature a piece by Dr. Elizabeth Rea on cuts to federal health care coverage for refugees. We also highlight PHAC’s recent 2010 TB data release, remind our readers of the upcoming North American Region conference of the International Union Against Tuberculosis and Lung Disease, feature the global Stop TB response to recent Global Fund changes, and highlight Canadian TB research published so far this year, amongst other things.

Please feel free to share this newsletter with your colleagues. If you’d like to stop receiving the newsletter, simply email us and we’ll take your name off the distribution list. You can also email us if you’d like someone to be added to the distribution list.
Cuts to federal health coverage for refugees: what it means for TB

By Elizabeth Rea

Under federal immigration minister Jason Kenney, Citizenship and Immigration Canada (CIC) has initiated major reforms of refugee policy over the last 2 years. As of July 1, 2012 significant cuts to the Interim Federal Health (IFH) program went into effect. IFH is the federal health insurance provided to refugees; it dates back to 1957 as part of a long tradition of refugee settlement in Canada.

There are 2 major components to the changes:

1) The coverage provided now varies by immigration status:
   - refugee claimants and privately sponsored convention refugees get coverage for care “of an urgent and essential nature” only, as outpatient and inpatient, including labs and investigations; however, no drug plan or any other supplemental benefits. This means, for example, that a patient admitted to hospital due to ketoacidosis from uncontrolled diabetes (“diabetic coma”) will be covered while in hospital, but their insulin will not be covered post discharge. No preventive or screening care is covered except prenatal. About 80% of refugees get this level of coverage.
   - government assisted refugees (GARs) get essentially the same coverage as the previous IFH program; it is roughly equivalent to provincial health plans, plus supplementary benefits available to Canadians on welfare (eg drug benefits, emergency dental, limited vision care, mobility devices, long term care, ambulance)
   - those whose claim has been rejected, or are in immigration detention, and refugees whose claim has been accepted but are waiting for coverage through a provincial health plan, get “public health and safety” coverage only.

2) One of the most controversial changes is that refugee claimants from “designated countries of origin” (DCO) will only be given “public health and safety” coverage. DCOs are intended to be countries from which a large proportion of refugee claims are historically rejected. The list of DCOs will apparently be developed late in 2012 and enforced in early 2013; it is expected to include Hungary, where many Roma refugee claimants come from.

As a group, refugees are among the most vulnerable people in Canada. Minister Kenney has said that the changes were made in part for fairness – that refugee claimants should not be entitled to more than Canadian citizens. But the vast majority of refugees have far fewer supports and social/financial safety nets than other poor Canadians, they may not be eligible for provincial support programs, and many have significant health issues ranging from pregnancy to PTSD following rape and civil war to untreated chronic disease. Many refugees will also go on to become Canadian citizens; refusing them access to health care on arrival is causing very real human suffering, sometimes preventable permanent disability – and it’s incredibly self-defeating.

Operationally, since July 1 there have been worrying delays (several months) in getting IFH coverage even for those who are entitled, if they make their refugee claim “in-land” rather than immediately at the port of entry. Provinces and territories must pick up the tab in the meanwhile for those who are ill enough to seek care; others simply go without, including pregnant women. At the local level increasing numbers of physicians have been refusing to even see IFH patients due to the restrictions on coverage and confusion about what is covered; although the DCO provisions are not yet in effect, many refugees from countries likely to end up on the DCO list believe they already have no coverage. At the volunteer Clinic for the Uninsured in Toronto, visits have almost tripled since the cuts, many presenting with severe disease.

“Public health and safety” coverage is the most concerning for TB. This category is intended to cover only situations where Canadians may be at risk from an ill refugee. CIC includes only 2 situations. The first is diagnosis with one of 23 conditions which are on the nationally notifiable communicable disease list, pose a risk of human-to-human transmission, and for which public health intervention is required. Tuberculosis has been used repeatedly as an example; malaria is not on the list (it’s not communicable person-to-person). The other category is a mental health condition posing a direct risk to others (eg psychosis with active threats of violence to others; suicidality is not covered). No other conditions, including pregnancy and delivery, are covered.

IFH “public health and safety” coverage will pay for the investigation of suspect TB (though apparently a maximum of 2 visits; it is unclear whether there are restrictions on the extent of lab/radiology/other investigations). However, since these individuals have no other coverage, they can be charged the full cost if their illness doesn’t fall into “suspect TB” (or one of the other 23 infectious diseases). People get ill with symptoms, not a diagnosis – if their fever, exhaustion, shortness of breath, and weight loss turns out not to fit the doctor’s diagnosis of “a suspect case of something on CIC’s list” they are liable to be handed bills well beyond the ability of most refugees to pay. Hospitals and provincial ministries of health will be left to absorb costs previously paid by the federal government.

By far the most concerning issue is that this policy is a massive disincentive to seek care – what if it’s not TB and I’m charged $650 just for walking into the ER? The result

Continues on Page 3
will be delays in diagnosis of TB, prolonged transmission in the community, and more advanced disease at the time of diagnosis. Study after study has shown that charging for health care is the biggest barrier to receiving it, particularly for the poor. As a public health and safety measure, this policy is not likely to be effective; in fact it is likely to result in additional, prolonged risk to Canadians when refugees from DCOs or whose claims have been rejected fall ill with TB.

Also concerning, we have been informed by senior CIC policy staff that IFH will only pay for direct treatment of the condition itself — anything else is considered a complication and will not be covered. This means IFH will cover only the actual TB antibiotics — no steroids for TB meningitis, no anti-emetics for patients with severe nausea, no blood monitoring for those who develop thrombocytopenia on rifampin. Similarly, at present IFH will only cover antiretrovirals for those with HIV — none of the routine measures to prevent opportunistic infections will be covered, no matter how cost-effective or how low the CD4 count.

Protests against the cuts to IFH started in the spring and have continued through the summer. On June 18th, Canadian Doctors for Refugee Care helped organize demonstrations in 14 cities across the country that were attended by more than 2,000 health providers. The organizations who have formally opposed the cuts include:

- College of Family Physicians of Canada
- Royal College of Physicians and Surgeons of Canada
- Canadian Association of Optometrists
- Canadian Association of Social Workers
- Canadian Dental Association
- Canadian Medical Association
- Canadian Nurses Association
- Canadian Pharmacists Association
- Canadian Association of Community Health Centres
- Canadian Doctors for Medicare
- Canadian Association of Midwives
- Registered Nurses Association of Ontario
- Canadian Federation of Nurses Union
- Canadian Psychiatric Association
- Canadian Paediatric Society
- Association of Medical Microbiology and Infectious Diseases Canada
- Médecins du Monde
- Public Physicians of Canada
- Ontario’s Council of Medical Officers of Health
- Canadian Association of Occupational Therapists

You can find more information from Citizenship and Immigration Canada:

and Canadian Doctors for Refugee Care, including ways to get involved:
http://www.doctorsforrefugeecare.ca/index.html

Write to your own member of parliament, or to Hon. Jason Kenney - Minister of Citizenship, Immigration and Multiculturalism - at 613-992-2235 / jason.kenney@parl.gc.ca / Fax - 613-992-1920 to express your opposition to the federal government’s cuts to health care services for refugees…and your concerns about real access to TB diagnosis, treatment, and prevention for refugees.

Follow Stop TB Canada on Twitter By Jennifer Gardy

Are you on Twitter? This social media platform allows people around the world to “tweet” - publish short messages online that other Twitter users can subscribe to. By “following” other users – subscribing to their updates – you can keep abreast of whatever you fancy - celebrity gossip, breaking news, your friends’ comings and goings, and even science!

Several scientific and health organizations around the world use Twitter to keep their followers informed about the latest developments in health and medicine, new research, conferences and other outreach events, and advocacy. Following organizations such as the World Health Organization (@WHO), CDC Atlanta (@CDCgov), and the global Stop TB initiative (@StopTB) is a great way to keep in the loop around global health.

Stop TB Canada has recently started a Twitter account and we encourage you to follow it for updates highlighting the latest in Canadian TB research. You can find us at http://twitter.com/StopTBCanada. You can either subscribe to our feed if you have your own Twitter account, or just visit that URL every so often for the latest updates.

For more on how Twitter can help you as a scientist or clinician, check out this great blog post or this one here.
Tuberculosis in Canada: PHAC 2010 Data and outbreak in Nunavik

By James Johnston

Provisional data from the Public Health Agency of Canada notes 1577 new active and retreatment TB cases reported to the Canadian TB Reporting System in 2010. This corresponds to an incidence of 4.6 per 100,000, the lowest national TB rate on record. However, significant regional variability exists. Most concerning is the high incidence of TB in Nunavut; the territory reported 108 TB cases in 2010, corresponding to a rate of 304 per 100,000 and nearly double the number of cases reported in 2009.

In other provinces and territories, the number of cases reported was generally stable. Maritime Provinces report the lowest TB rates, with rates less than 2 per 100,000 in Newfoundland and Laborador (1.6/100,000), Nova Scotia (1.1/100,000), New Brunswick (1.3/100,000) and Prince Edward Island (0.7/100,000). Over two-thirds of cases occurred in Ontario (4.8/100,000), British Columbia (5.3/100,000) and Quebec (2.6/100,000).

Meanwhile, rates in Alberta (3.6/100,000), Saskatchewan (7.8/100,000) and Manitoba (10.7/100,000) were generally stable. The report is available online at http://publications.gc.ca/collections/collection_2012/aspc-phac/HP37-5-1-2010-eng.pdf.

In the Nunavik region of Northern Quebec, a large outbreak of TB is moving closer to resolution. Since November 2011, 89 cases have been reported to local authorities in Kangiqsualujjuaq. Extensive clinical and radiological screening was undertaken in August 2012, and the Ungava Tulattavik Health Centre, McGill Health Centre, and Nunavik Region Board of Health and Social Services are continuing to monitor the situation. Trilingual outreach materials have been made available to the community.

International news from Stop TB

Here are selected summer headlines from the international Stop TB initiatives - follow the links to read the full articles.

- Update: Global Drug Facility enters a new era
- World Bank President Jim Kim blogs on TB, mining and Africa
- Overcoming Tuberculosis now available in Russian language version
- Southern African heads of state join forces to end tuberculosis in the mining sector
- Cost of Xpert cartridges to drop 40 percent
- BD and PEPFAR launch Labs for Life initiative
- TB Alliance study raises hope for shortened treatment of drug-sensitive and drug-resistant TB
- TB REACH launches call for proposals for Wave 3

Save the Date!

17th Annual Conference of the IUATLD, North American Region

February 28-March 2, 2013
Sheraton Wall Centre
Vancouver, BC

Abstracts due October 5

The 17th Annual Conference of the Union-North American Region is now accepting abstract submissions. The deadline is October 5, 2012.

Travel grants are available to individuals who are unlikely to attend the conference without the grant or who reside or work in the Caribbean, Central or South America.

For more information contact: Dr. Menn Biagtan at: 1.604.731.5864 or e-mail: biagtan@bc.lung.ca or visit our website at www.bc.lung.ca

Upcoming Conferences

43rd Union World Conference on Lung Health
Driving sustainability through mutual responsibility
13 - 17 November 2012, Kuala Lumpur, Malaysia

44th Union World Conference on Lung Health
Shared air, safe air
30 October - 3 November 2013, Paris, France
WHO/Stop TB Partnership reaction to
Global Fund Changes

By James Johnston

Recently, the WHO and Stop TB Partnership released a statement in response to proposed changes in the Global Fund (GF) allocation structure. The GF Board is currently discussing a model that would limit TB funding to 16%. Undoubtedly, this would have hugely adverse effects on global progress against the TB epidemic. The Stop TB Secretariat estimates that changes in GF allocation would result in a funding gap of over $2 billion per year and would halt or reverse global scale-up of TB efforts. The proposed allocation model does not represent equitable distribution among the three GF diseases. A fair share would be measured according to mortality (34%), DALYs (27%) or funding gap per disease (22%).

Please read the discussion paper, available at this link, endorsed by the Stop TB Secretariat, including more than 60 individuals and organizations. For more information or feedback, please email: stopthadvocacy@who.int

The Global Fund and Huffington Post launch
“The Big Push” online rally

By Jennifer Gardy

Together with the online news source The Huffington Post, the Global Fund recently launched an online campaign called The Big Push. The campaign is an online effort to catch the attention of decision-makers and ensure that efforts to reduce TB, HIV, and malaria remain at the forefront of our political leaders’ minds. The dream is a world where no deaths are caused by tuberculosis or mosquito bites, and no children are born with HIV.

To participate, visit The Big Push’s website, where you can download one of many signs. Take a portrait of yourself holding the sign, and upload it to the Big Push wall. The campaign has already seen several big names lend their voices and support, including Bono, Charlize Theron, and WHO Director General Margaret Chan.

Add your voice today!

Politicians, business people, celebrities, and health advocates from around the world have already added their voices to The Big Push campaign. From left to right, UN Secretary General Ban Ki-Moon, philanthropist and Microsoft founder Bill Gates, UK lawyer and wife of the former Prime Minister Cherie Blair, and former first daughter and news correspondent Chelsea Clinton.
Canadian tuberculosis research highlights: selected publications released in 2012

Canadian researchers have been busy in 2012, publishing over 60 papers on tuberculosis so far! Here’s a small selection.


Ahmed R, Cooper R, Foisy M, Der E, Kunimoto D. Factors Associated with Reduced Antituberculous Serum Drug Concentrations in Patients with HIV-TB Coinfection. J Int Assoc Physicians AIDS Care (Chic).


Field SK, Fisher D, Jarand JM, Cowie RL. New treatment options for multidrug-resistant tuberculosis. Ther Adv Respir Dis.


Menzies D. Hammering the point home: serologic testing costs more and harms more patients than other strategies for the diagnosis of active tuberculosis in India. Evid Based Med. 17(2):58-9.


Pai M. As India grows, tuberculosis control must not be left behind. Lancet Infect Dis. 12(4):263-5.


Reitmanova S, Gustafson DL. Exploring the mutual constitution of racializing and medicalizing discourses of immigrant tuberculosis in the Canadian press. Qual Health Res. 22(7):911-20


JOIN THE STOP TB CANADA INITIATIVE

Stop TB Canada members receive a $30.00 discount on registration to the IUATLD North American Region, and have the opportunity to participate in community engagement and organizational events. Annual dues are $25.00 for trainees, $50.00 for regular members, and $100.00 for an organizational membership.

For more information or to join, email Dr. Menn Biagtan at biagtan@bc.lung.ca.