



12th Annual Conference IUATLD-NAR

Ms. Joy Marshall has no financial relationship with companies who have provided support to this meeting that suggests a personal conflict of interest in relations to the planning for the above captioned CME Event.

Enhanced Surveillance for TB in a Decentralized TB System: Unique Challenges

Joy Marshall, MN

TB Nursing & Allied Health Collaboration Across Borders

IUATLD, February 28, 2008

San Diego, California



Objectives: 1

- Describe a situation where Ontario, Canada received more than 300 refugees at high-risk for TB (and MDR TB)
- Decentralized TB clinic system
- No established procedures for screening high-risk refugees
- Development of an enhanced TB surveillance system nationally and provincially to minimize public health risk
- Challenges/successes
- Implications for future migrations

Objectives: 2

- Describe the challenges of identifying TB in a high-risk refugee population
- Identify challenges of a decentralized TB management system
- Discuss strategies to identify active disease in high-risk refugee population to minimize public health risk
- Identify policy and procedural implications associated with migration of refugees from an area endemic for TB

How it began

- In June 2006, the Canadian Minister of Citizenship and Immigration announced that 810 Burmese refugees, “the poorest of the poor,” were expected to migrate to Canada
- Ontario would receive approximately 300 between August and September 2006
- All would have security clearance and preliminary medical assessment prior to arrival

What did we know about the refugees?

- Belonged to a Myanmar ethnic group called the Karens
- Camp located in northern Thailand – Mae La Oon Camp
- Since 1997, refugees have lived in crowded, remote camps
- Some refugees have never left the camps since birth

Where is Burma?



Where do the Karen come from?



Refugee camps are on the border of Thailand and the former Burma (now called Myanmar)





Tom Reese © Seattle Times



Tom Reese © Seattle Times

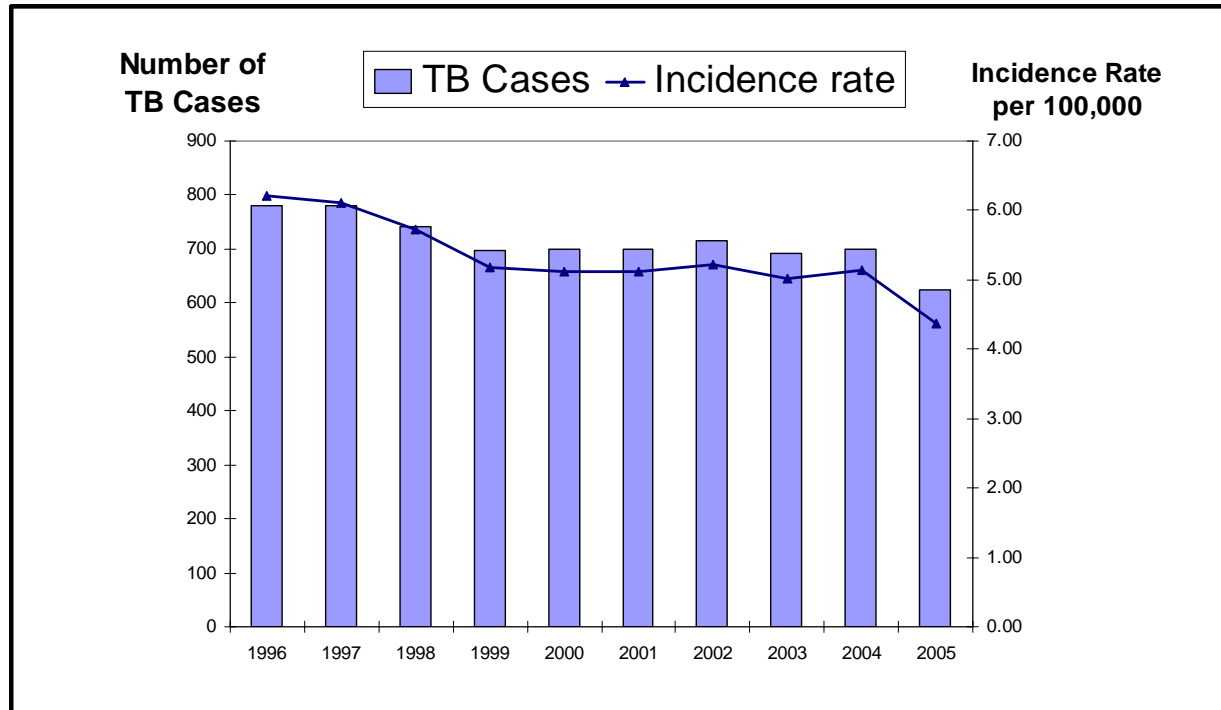


Tuberculosis rate!

- Rate of 2674/100 000 in the camps over the past two years
- 10% = MDR
- Among the Hmong (similar refugee camps nearby) 30% = MDR

TB Management in Ontario

TB Incidence Rate in Ontario 1996-2005



Citizenship and Immigration Canada (CIC)

- Discussions with provincial partners
- Discussion with Immigration Subcommittee of the Canadian TB Committee to discuss “enhanced surveillance”
- Liaise with local public health authorities – 3 urban health units who would be getting refugees

Federal response

- CIC shortened validity period of medical from 12 months to 9 months
- Persons with abnormal CXRs screened for TB
- Active cases held back (along with families) until they completed a course of anti-TB therapy

Fit to Fly

- New Fit to Fly: pre-departure screening overseas done within 72 hours of departure
- If there are concerns at time of flight, review of Immigration Medical Examination
- If invalid (i.e. > 9 months since IME done), CXR would be repeated
- Used basic questionnaire for Fit to Fly
- Included symptom check, basic physical examination, TPR, skin and scalp check and auscultation of heart and lungs
- If concerns – held back

Assistance to health care providers: prepared by Citizenship and Immigration Canada

- “Karen Refugees – Information for Canadian Primary Care Professionals”
- “Karen Refugees – Information for Canadian Public Health Officials”
- “Welcome to Canada” handout in English
- Information about CIC’s policy and health information related to Thailand refugee camps
- Suggested medical management of refugees
- Expedited Interim Federal Health funding

Karen Refugees: Information for Canadian Primary Care Professionals

Prepared in collaboration with the Public Health Agency of Canada and the Medical Services Branch, Citizenship and Immigration Canada.

Key information to help professionals provide care to Karen refugees.

This document comprises the following sections:

- Information on Canada's Immigration Medical Examination
- Health Information on Mae La Oon Camp in Thailand
- Health Information on Other Refugee Camps in Thailand
- Suggested Medical Follow-up by Canadian Primary Care Professionals
- Public Health Follow-up in Canada
- Contact Information for Health Insurance and TB Issues
- References for Specific Health Conditions

In the meantime

- American experience documented in MMWR on August 5, 2005
- In 2003, there were 12,707 Hmong from Laos living in Thailand; 14,000 were going to be resettled in the USA
- Between January 2004 and January 2005: 9,459 Hmong arrived; 37 cases of TB; 4 = MDR
- Suspension of travel to USA
- Revised screening algorithm
- Started resettlement on February 16, 2005, and no new cases of TB found upon arrival in USA

Discussions with CDC

- Ontario very concerned with high rate of TB reported in the camps
- Reviewed medical assessment validity of USA of 3 months not 9 months; suggested to CIC a 6-months validity of IME
- Wanted CXR and medical records to arrive with refugees
- Discussion with CIC and CDC about CDC's experience "on the ground" in the camps, and their enhanced surveillance protocol

Ontario's approach

- Teleconference with key TB clinicians in Toronto who had dealt with previous TB MDR outbreak earlier in 2000s
- Also public health staff who had experience with refugee migration and MDR outbreak (included representatives of the 3 health units expecting refugees with this migration)
- All aware of the limitations within our system
- Plan of action formulated

Ontario's enhanced surveillance and screening of high-risk refugee group

- All refugees to have a CXR and basic assessment for TB within days of arrival
- Basic immunization would be offered if possible (to allow children to start school ASAP)
- Arrangements made with local refugee reception houses to extend normal stay of a few days to at least a week to allow for above steps to occur

The best laid plans

- At literally the last moment, found that a fourth city would be getting the largest number of refugees
- No TB clinic; nor had they been involved in any of the planning or information sharing or education sessions we'd had with clinicians and CIC!

And then...

- Came martial law/political coup in Thailand and refugees were not allowed outside the refugee camps – any refugees who were “on their way” were ordered back to the camps
- Flooding (torrential) and people could not move out on the roads – had to go by boat to the planes: delays
- Conjunctivitis in camps – movement delayed
- Unfitness to fly noted in first groups

What we found

- First case found in early arrivals (prior to ours) in Saskatoon, Saskatchewan
- In November 2006, one case of TB diagnosed in newly arrived refugee in Hamilton
- In January 2007, a second case in Ottawa
- In November 2007, a third case in Hamilton
- 3 cases in 353 refugees = 850/100 000

Evaluation: What went well

- Dialogue at all levels – with CIC, Canadian TB Committee, local clinicians, local public health authorities and CDC – sharing of experiences and information most helpful
- Advance notice (for the most part)
- None of the refugees declined care
- Finding active cases quickly
- Interim Federal Health funding in place
- Print material for providers

And not so well

- Fall is very busy for public health – strain on resources and enhanced surveillance of these refugees deemed to be a burden
- Cost for translators and taxis not picked up and absorbed into health unit budgets
- Significant challenges for health care providers to get paid by IFH
- Competing interests to assess only TB when also needed to screen for malaria, shistosomiasis, etc.
- Challenge to find interpreters (NO material provided by CIC about Karens or translated material provided)
- Coordination was difficult – clinics sat empty when refugees did not come on time

Inequity

- Local agencies and health professionals who work with refugees on an ongoing basis were concerned that this group of refugees were singled out for special treatment
- They deemed other refugees to be in just as urgent need for medical attention and the Karens were “fast tracked” ahead of these others in the same settlement houses

Considerations for future migrations: 1

Policy discussion and decisions:

- Should all refugees be medically re-assessed upon arrival?
- Should settlement houses and medical organizations who work with refugees have more resources to let people stay longer?
- Should this type of migration only take place where there are settlement houses and refugee/medical infrastructures in place for their care?

Considerations for future migrations: 2

- Longer stays in reception houses might be valuable
- Better coordination of care and resources
- Access to care beyond immediate arrival for refugees
- Consider dental care to be provided (not just medical)
- Should health care professionals be provided with screening guidelines for newly arrived refugee populations?

Considerations for future migrations: 3

- Centralized location for assessment after arrival
- Medical records to accompany refugees
- CXRs should be available through CIC (difficult for refugee to carry, but CD or easily accessible film should be provided)

Changes: 1

- Second group of 500 Karen refugees arrived in 2007
- Expanded from 4 cities to now 10 (some health unit jurisdictions have minimal access to TB specialists or respirologists for screening)
- CIC has enhanced reading of overseas CXRs
- Enhanced lab capacity (in first round never determined sensitivity of cases overseas)
- All newly arriving Karen refugees to come with copy of medical record (no CXR just report)
- Smoother notification of provincial authorities of who is coming, when and where

Changes: 2

- Although there are many challenges with refugees arriving in small health unit jurisdictions, all public health jurisdictions in Ontario have had education sessions about the first Karen experience, so they were somewhat prepared
- This time around, Ontario left it to local public health authorities to decide about lengthening stay in settlement houses and decision to provide CXRs upon arrival

Changes: 3

- Each health unit arranged for longer stays and provision of CXRs
- Despite concerns about workload and inequality, risk to public health deemed to be larger
- To date, of 500 refugees, <10 have been identified as PTI (pulmonary TB infection)
- Immediate notification and CXR provided as soon as refugee arrived; no TB cases in these PTI
- However, in January 2007, new case of TB in refugee not deemed to have had abnormal CXR overseas
- None of the cases diagnosed in Ontario were MDR

To make it work

- Resources for CIC and local public health authorities
- Centralized screening by experts in migration health needs
- Translated materials

Resources: 1

- Morbidity and Mortality Weekly Report, August 5, 2005/Vol. 54 No. 30, “Multi-Drug Resistant TB in Hmong Refugees Resettling from Thailand into the United States 2004-2005.”
- “Karen Cultural Profile: A Tool For Settlement Workers and Sponsors” (May 2006) IOM International Organization for Migration: Bangkok, Thailand.
- “Burmese Cultural Profile” (May 2006) IOM International Organization for Migration: Bangkok, Thailand.
- Martin, Veronika (2004) “Myanmarese Refugees in Thailand: No Freedom, No Choices” in World Refugee Survey.

Resources: 2

- “Evaluation of TB Program Services for Burmese Refugees in Thailand Resettling to the United States, June 2007,” July 18, 2007. Charles Nolan et al.
- CDC Immigration Requirements Technical Instructions for TB Screening and Treatment 2007
- Karen Refugees – Information for Canadian Primary Care Professionals

This document was prepared in collaboration with the Public Health Agency of Canada and the Medical Services Branch, Citizenship and Immigration Canada.

Resources: 3

- Karen Refugees – Information for Canadian Public Health Officials

This document was prepared in collaboration with the Public Health Agency of Canada and the Medical Services Branch, Citizenship and Immigration Canada.

Questions?

- For more information:

Joy Marshall, MN

TB Nurse Consultant

Ministry of Health and Long-Term Care

Ontario, Canada

joy.marshall@ontario.ca

Thank you.