3. Caulford P, Yasmin V. Providing health care to medically uninsured immigrants and refugees. CMAJ 2006; 174:1253–4.

4. Office of the United Nations High Commissioner for Human Rights. International Covenant on Economic, Social and Cultural Rights; December 16,1966: 993 U.N.T.S. 3, art. 12.

5. United Nations Economic and Social Council Official Record. General Comment No. 19: The right to social security (Art. 9 of the Covenant), UN ESCOR, 39th Sess., UN Doc. E/C.12/GC/19 (2008) at para. 37.

6. Pottie K, Greenaway C, Feightner J, Welch V, Swinkels H, Rashid M, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011; 183:E824–E925.

7. CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health), CEDAW, 20th Sess., UN Doc. A/54/38/Rev.1, chap. I (1999) at para. 27; Convention on the Elimination of All Forms of Discrimination against Women, 18 December 1979, 1249 U.N.T.S. 14, art. 12(2).

8. Bisaillon L. Mandatory HIV screening policy and everyday life: a look inside the Canadian immigration medical examination. Aporia 2011; 3:5–14; 15:84–6; WHO & UNAIDS. Guidance on provider-initiated HIV testing and counselling in health facilities, May 2007.

The Society of Obstetricians and Gynaecologists of Canada's Position Statement on Federal Budget Cuts to the Interim Federal Health Program

To the Editor:

On June 4, 2012, the Society of Obstetricians and Gynaecologists of Canada published a position statement on cuts to the Interim Federal Health Program[1] that declared "We are pleased that refugee claimants will continue to have access to the obstetric and gynaecologic services they require."

In stark contrast, health organizations including the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, the Canadian Association of Optometrists, the Canadian Association of Social Workers, the Canadian Dental Association, the Canadian Medical Association, the Canadian Nurses Association, the Canadian Pharmacists Association, and the Canadian Association of Midwives called for rescinding of these cuts.[2] Even Citizenship and Immigration Canada's Director General of Health, Dr Danielle Grondin, could not call this a good health decision.[3]

The SOGC mission is "to advance the health of women through leadership, advocacy, collaboration, outreach, and education." Sadly, here it fails on all counts. Apparently there was no outreach to those caring for refugees, and no collaboration with the organizations above. Advocacy and leadership through this statement excluded the most vulnerable among us, often those who came seeking refuge from horrific conditions, without the supports and capacities of most Canadians, and public education with this press release was based on inaccurate information in terms of who was covered for what conditions.

The statement claims that "[a]11 prenatal, delivery and postpartum health services" will continue to be covered, later qualifying this to note that it might be untrue for "a select few refugee claimants based on their designated country of origin." According to Citizenship and Immigration Canada, obstetrical services available to those from designated country of origin (DCO) countries are, literally, none.[4] "Urgent or essential gynaecologic services" are not covered for DCO women, unless the conditions needing treatment, possibly including STIs but excluding mental health services such as counselling for rape victims or even suicidal ideation, become an issue for public health or safety.

Coverage for medication for all refugees, including invited government-assisted refugees, was eliminated. Having cared for hundreds of refugee women, I can assure you that such women couldn't afford supplies to manage their diabetes in pregnancy. Ironically, if an Iraqi refugee had remained in temporary housing in Jordan, such medication would have been a fraction of the price in Canada, and had the Congolese woman remained in a refugee camp an international non-governmental organization would have provided her drugs. Providing comfort to claimants, the statement advises "alternate avenues for service exist and . . . products such as contraception may be accessible to them via compassionate programs."[1] How will this be communicated to refugees, by whom, and in what language?

"In conclusion, the SOGC recognizes that spending from the public purse in support of health services is reaching crisis proportions. . . . products and services must be dispensed in a fair and equitable manner. . . ."[1] Is leaving the pregnant woman with untreated hypertension to deliver a premature Canadian baby good crisis management? Will costs merely be offloaded to the provinces? Is this "fair and equitable?" Refugees are initially ineligible to receive social assistance, which covers all medication and services provided by IFHP.

Some would say that the government's decision appears to be based more on ideology than on evidence. Popular pressure from other medical organizations forced a tacit reversal regarding government assisted refugees on the eve of the implementation.[5] Which leads to the question: what prompted the SOGC statement?

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REFERENCES

1. Society of Obstetricians and Gynaecologists of Canada. Position statement: federal budget cuts to the Interim Federal Health Program; 4 June 2012. Available at: http://www.sogc.org/documents/medRefugeeHealthBenefitsStatementENG120604.pdf. Accessed June 5, 2012.
2. Linton L, Phelps F, Sutherland R, Haggie J, Mildon B, Poston J, et al. Letter to Minster Kenney. Available at: http://www.cfpc.ca/uploadedFiles/Publications/News_Releases/News_Items/kenney%20vers3%20-%20may2012.pdf. Accessed June 7, 2012.
3. As it Happens. The Wednesday Edition. June 20, 2012. Available at: http://www.cbc.ca/asithappens/episode/2012/06/20/the-wednesday-edition-33/. Accessed July 1, 2012.
4. Scholtens M. Medical Coverage—IFH changes. Refugee Health Vancouver web site. Available at: http://www.refugeehealth.ca/node/693. Accessed July 5, 2012.
5. Citizen and Immigration Canada. Interim Federal Health Program: summary of benefits. CIC web site. Available at: http://www.cic.gc.ca/english/refugees/outside/summary-ifhp.asp. Accessed June 29, 2012.

In Response

To the Editor:

I read with interest the letters from Dr Chen and Dr Aryan in response to the Society of Obstetricians and Gynaecologists of Canada's position statement[1] about federal budget cuts made to the Interim Federal Health Program (IFHP).

The SOGC was approached to endorse the joint position statement issued by a number of Canadian health care professional organizations opposing the proposed budget cuts to the IFHP. The SOGC declined, opting instead to invest the time required to conduct a careful review of relevant documentation and consult with health care professionals and Citizenship and Immigration Canada representatives, as well as immigration lawyers, before issuing a statement. The review and analysis led to the publication of a position statement solely intended to clarify the facts related to proposed changes to the IFHP as they specifically pertained to the field of obstetrics and gynaecology. This statement was issued on 4 June, 2012.[1]

In this statement, the SOGC clearly acknowledges that access to health benefits for refugee claimants from designated countries of origin, including services in obstetrics and gynaecology, may be affected. At this time, the government has not identified these countries and the effect of the proposed changes to the IFHP has yet to be determined. The SOGC is awaiting further information on this very sensitive topic before determining if any additional follow-up is required.

As a strong advocate for women's health, the SOGC felt it necessary to broaden the scope of its assertions and follow up the release of our position statements about federal budget cuts to Aboriginal health funding (25 April)[2] and the IFHP (4 June)[1] by issuing a third position statement (6 July)[3] focused on health benefits for *all* vulnerable populations in Canada including Aboriginal, homeless, and geriatric Canadians, as well as some minority groups and refugee claimants. We emphasize that if governments truly seek to achieve fiscal responsibility and equity for all existing and future Canadians, our health care system and social assistance programs must ensure that *all* individuals receive the health services and medications they require to achieve and maintain general overall health.

As responsible advocates for women's health, we should strive to achieve the ideal. However, we must recognize that while there is an endless list of health issues and concerns faced by Canadians, there are not unlimited human and financial resources to address them. Important, and albeit difficult, decisions must be made. For the government to make informed decisions, these must involve comprehensive consultations with health care professionals. Only then can we ensure the health of existing and future Canadians and maintain the strength of our health care system, today and in the future.

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REFERENCES

1. Society of Obstetricians and Gynaecologists of Canada. Position statement: Federal budget cuts to the Interim Federal Health Program; 4 June 2012. Available at: http://www.sogc.org/documents/medRefugeeHealthBenefitsStatementENG120604.pdf. Accessed July 23, 2012.
2. Society of Obstetricians and Gynaecologists of Canada. SOGC comment: Cuts to Aboriginal health funding risk worsening First Nations, Inuit and Métis women's health; 25 April 2012. Available at: http://www.sogc.org/media/guidelines_e.asp. Accessed July 23, 2012.
3. Society of Obstetricians and Gynaecologists of Canada. Position Statement: Health benefits for vulnerable populations in Canada; 6 July 2012. Available at: http://www.sogc.org/documents/medMargPopStatement120706.pdf. Accessed July 23, 2012.

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