HIV Primary Care : Considerations for Refugees

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March 26 2019
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UNHCR Roger Arnold

Family & Community Medicine
UNIVERSITY OF TORONTO

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WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED

Disclosures

- No commercial/ conflicting interests

Acknowledgements

Acknowledgement to our colleagues and the patients we serve, from whom we learn every day.

Objectives

1. Explain key approaches to caring for any newcomer refugee

2. Describe specific elements of care for the newcomer or refugee living with HIV/AIDS.

Overview

- Newcomer /Refugee Global Data
- Nomenclature
- Refugee Health Insurance
- Immigrant Medical Exam
- A Few Nuances of Refugee Intake and Primary Care

Who We Are

- Crossroads Clinic – opened in December 2011, 2 NPs, 3 Physicians, 2 medical secretaries, SW and 2 RPNs
- About 3900 patients
- Criteria – Refugee Claimant with Interim Federal Health Program (IFHP) coverage and in shelter housing
- Research and education focus – MD and NP students
- Advocacy
- Best Practice – based on Canadian Collaboration on Immigrant and Refugee Health (CCIRH) in CMAJ, July 2011

Immigration Categories

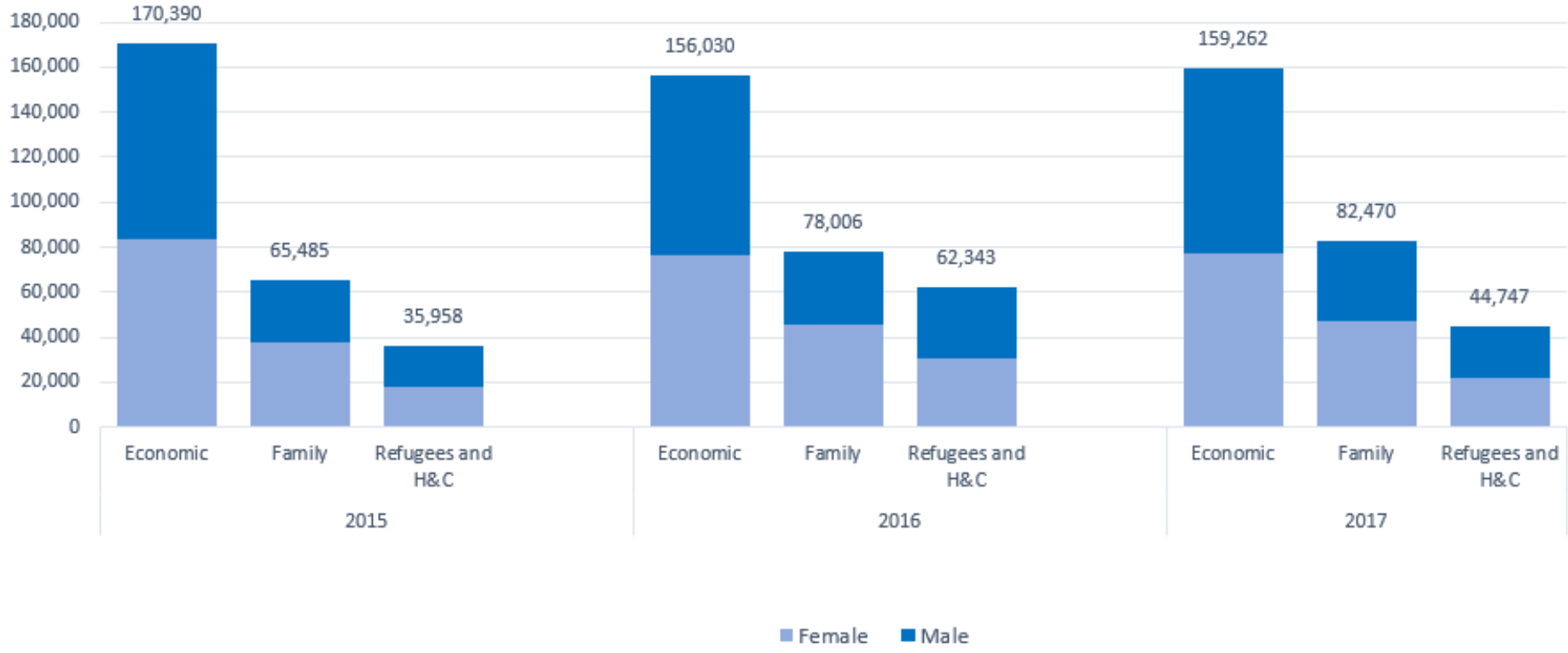
- How many people immigrate to Canada annually? How many refugees?
- Economic immigrants
- Family class
- Refugees
- Small number of “other”

Immigration to Canada, 2017

	Number	%	Comments
Economic Immigrants	159, 262	55.6%	Skilled worker, business class, live-in caregivers
Family class	82, 470	28.8%	Include spouses/partners, parents, grandparents and children
Refugees	44, 747	15.6%	GARS, refugees landed in Canada, privately sponsored, refugee dependents
Other		< 1%	Mostly H&C applicants
Total	**286, 479**	**100%**	

Immigration, Refugees and Citizenship Canada, 2017

Immigration to Canada Category 2015-2017



Immigration Refugees Citizenship Canada 2018 Report

Legal Definition of Refugee

1951 United Nations Geneva Convention Relating to the Status of Refugees:

- a person owing to a well-founded fear of being **persecuted**
- for reasons of race, religion, nationality, membership of a particular social group, or political opinion,
- is outside the country of their nationality, and is unable to or, owing to such fear, is unwilling to avail him/herself of the protection of that country

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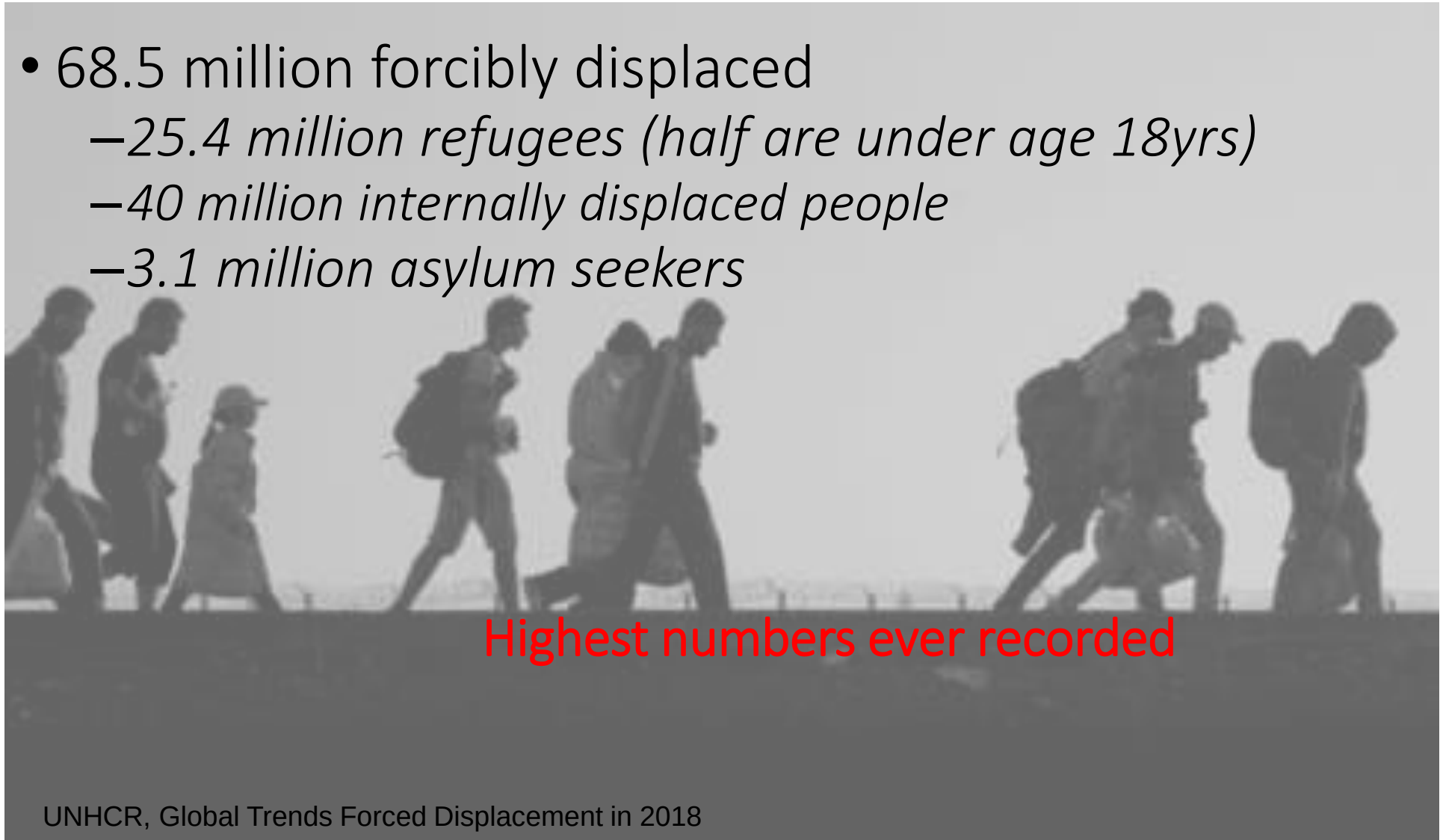
Global Refugee Migration, End of 2017

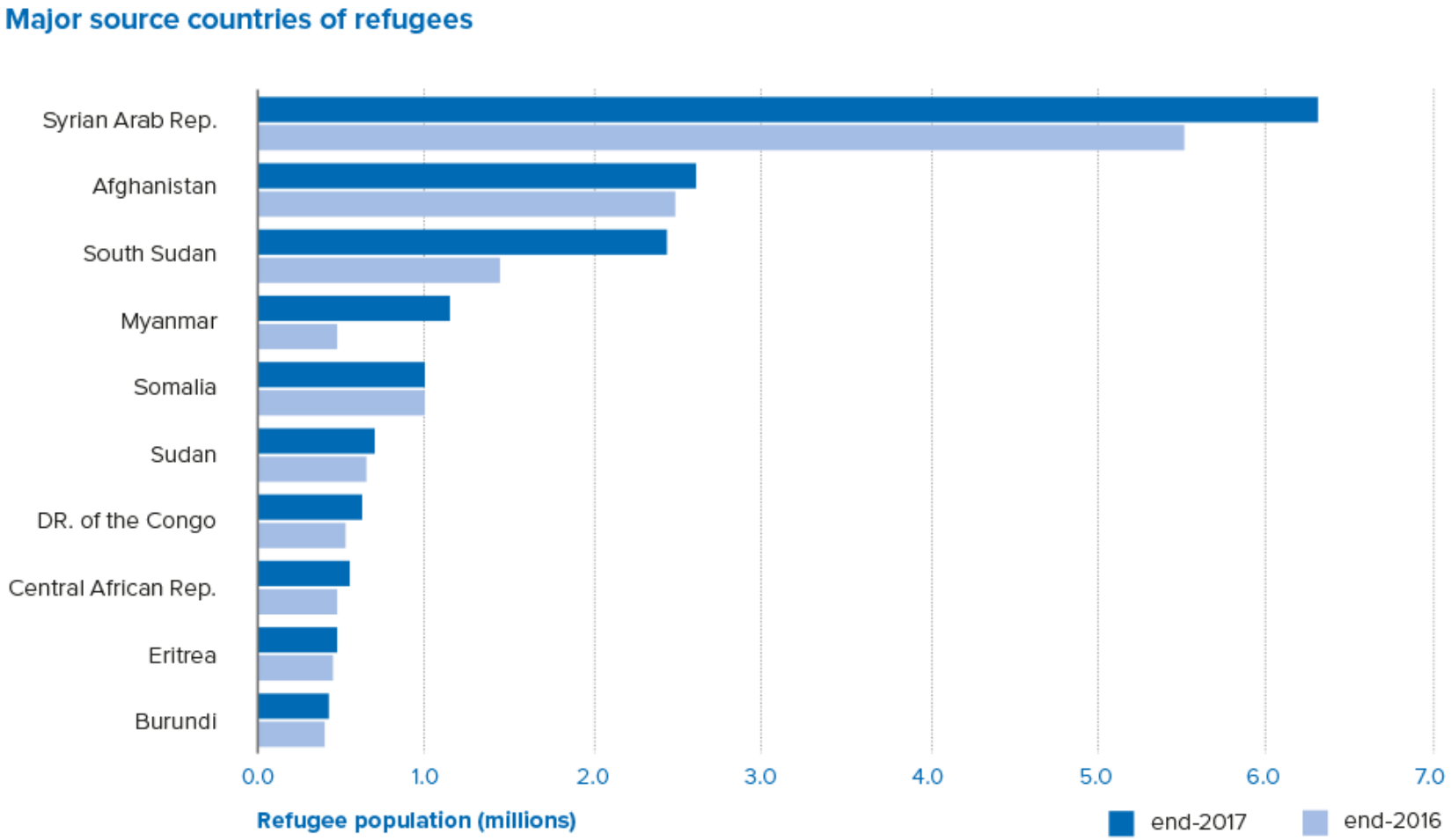


- 68.5 million forcibly displaced
  - *25.4 million refugees (half are under age 18yrs)*
  - *40 million internally displaced people*
  - *3.1 million asylum seekers*

Highest numbers ever recorded

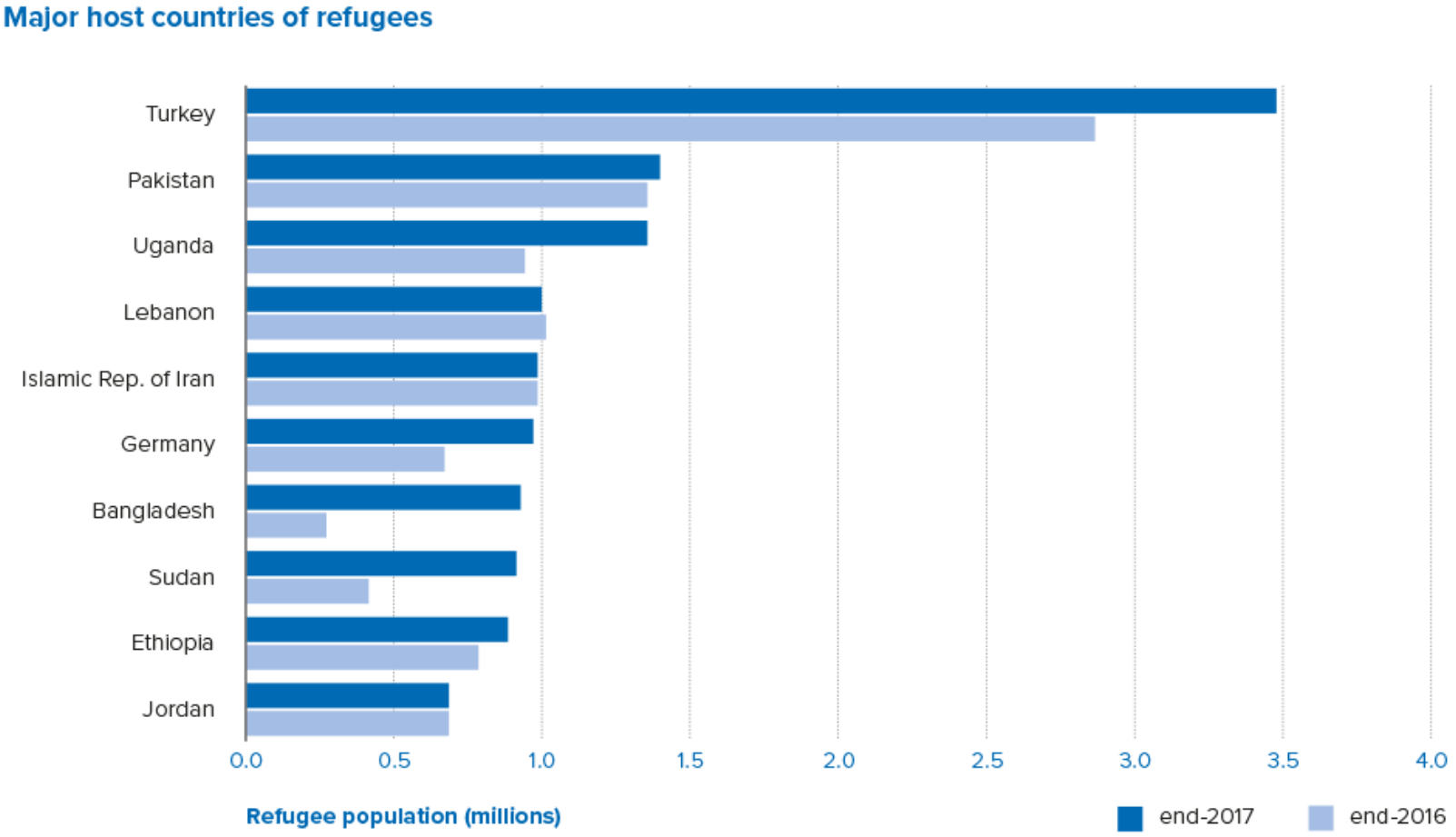
UNHCR, Global Trends Forced Displacement in 2018

Top Source Countries of Refugees, 2017



Source: UNHCR, Global Trends Forced Displacement in 2017

Who is Hosting the World's Refugees? 2017



Source: UNHCR, Global Trends Forced Displacement in 2017

Refugee Nomenclature in Canada

Resettled Refugees

- Government Assisted Refugees (GARs)
- Privately Sponsored Refugees (PSRs)

Refugee Claimants

- *elsewhere referred to as asylum seekers*
- *Note: distinction from other forced migrants, such as those without status*

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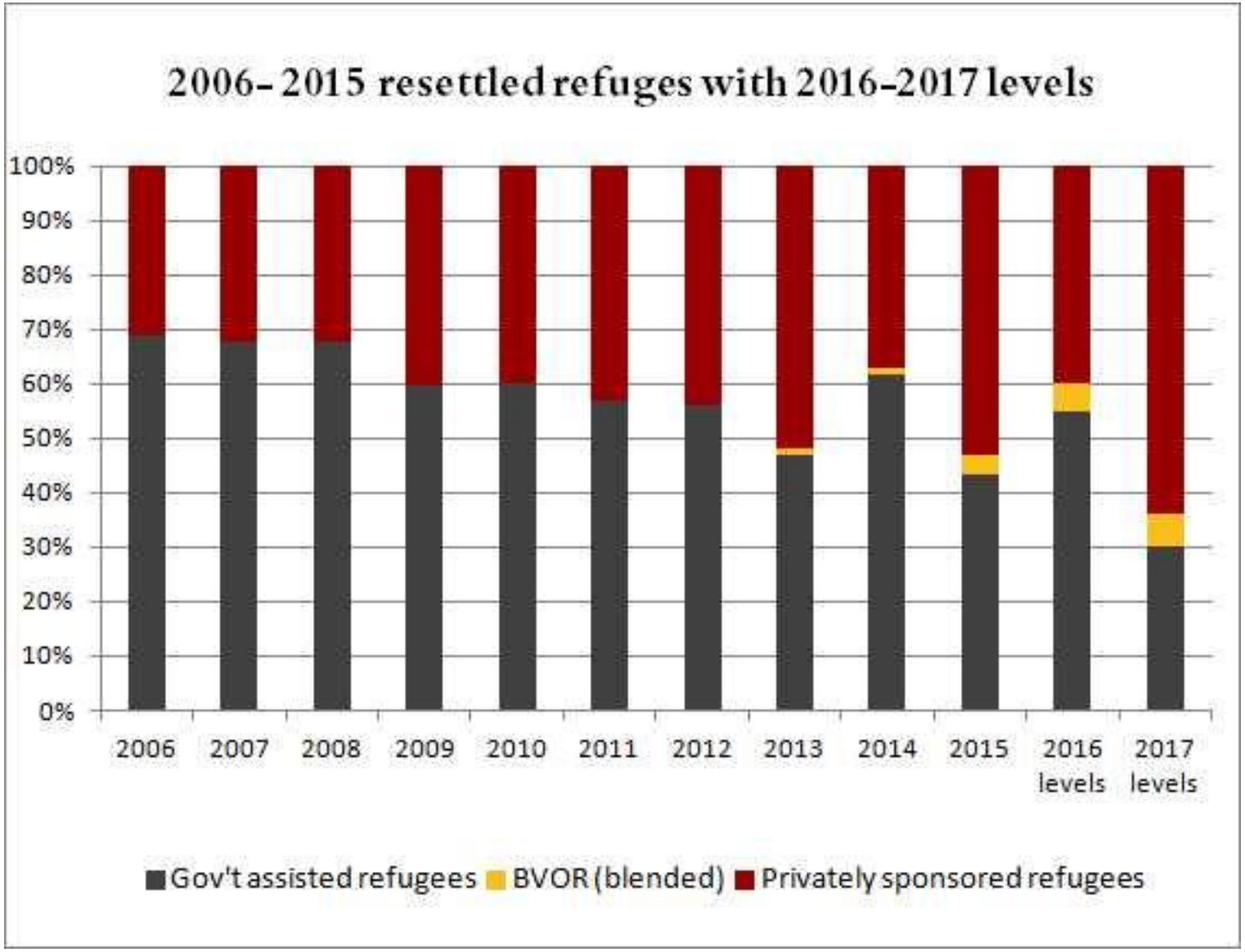
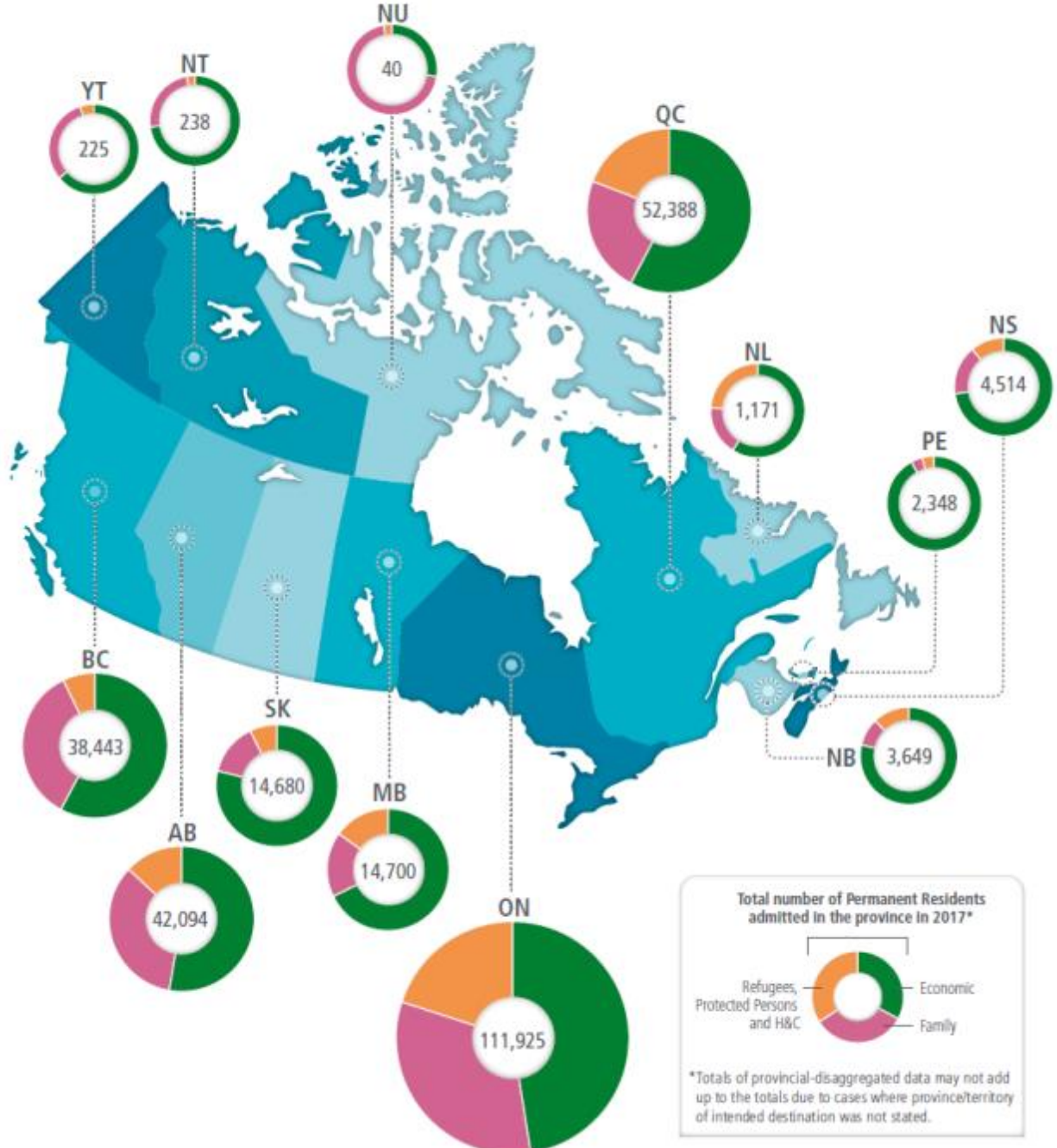
Canada's Refugees – The Breakdown…

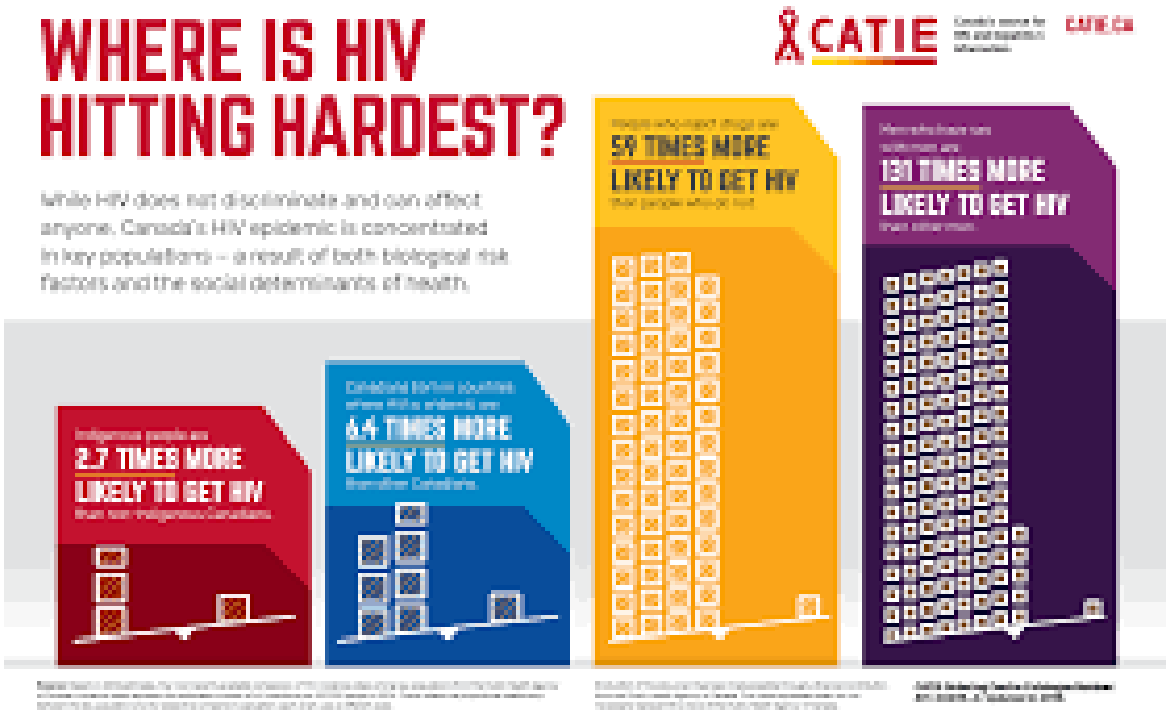


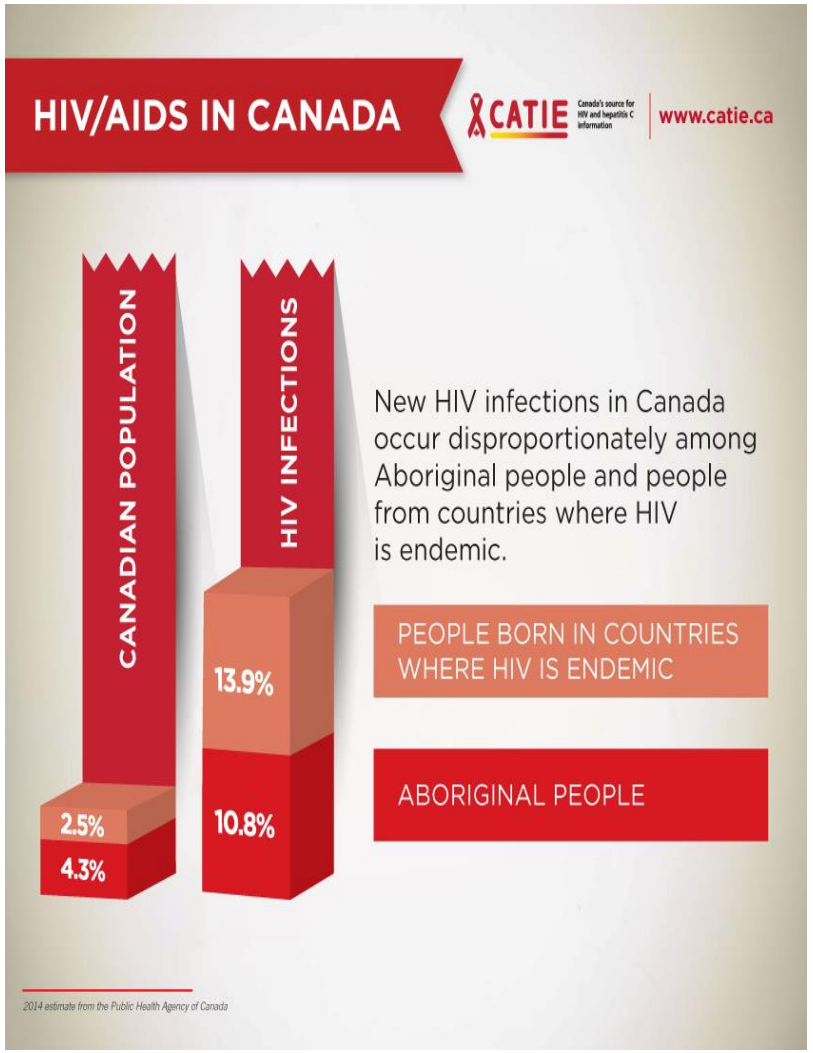
CANADA - Admissions of Permanent Residents

by Immigration Category and Province/Territory of Intended Destination, 2017



Are Refugees At Risk?





Avert www.avert.org Source: UNAIDS Data 2018

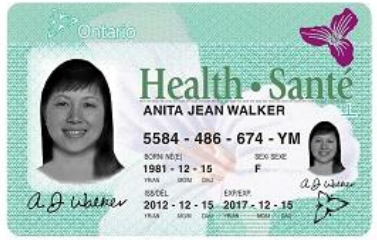
Health Insurance for Refugees

unhcr.org

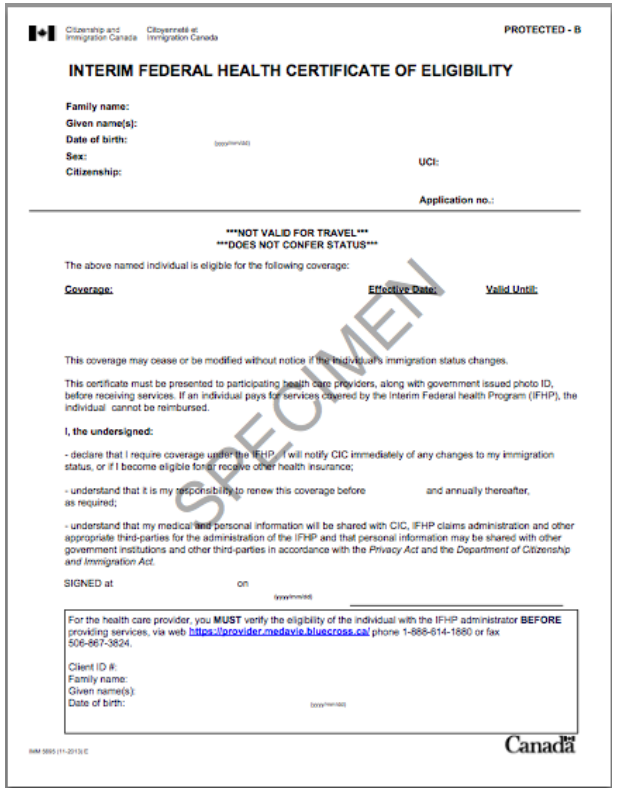
Health Care Coverage for PSRs/GARs

- Provincial health card on arrival
- IFHP for supplemental services for 1 year

  Typically receive after arrival through IRCC office



Settlement.org



Citizenship and Immigration Canada / Citoyenneté et Immigration Canada

PROTECTED - B

INTERIM FEDERAL HEALTH CERTIFICATE OF ELIGIBILITY

Family name:
Given name(s):
Date of birth:
Sex:
Citizenship:

UCI:

Application no.:

*****NOT VALID FOR TRAVEL*****
*****DOES NOT CONFER STATUS*****

The above named individual is eligible for the following coverage:

Coverage: **Effective Date:** **Valid Until:**

SPECIMEN

This coverage may cease or be modified without notice if the individual's immigration status changes.

This certificate must be presented to participating health care providers, along with government issued photo ID, before receiving services. If an individual pays for services covered by the Interim Federal Health Program (IFHP), the individual cannot be reimbursed.

I, the undersigned:

- declare that I require coverage under the IFHP. I will notify CIC immediately of any changes to my immigration status, or if I become eligible to or receive other health insurance;

- understand that it is my responsibility to renew this coverage before and annually thereafter, as required;

- understand that my medical and personal information will be shared with CIC, IFHP claims administration and other appropriate third-parties for the administration of the IFHP and that personal information may be shared with other government institutions and other third-parties in accordance with the *Privacy Act* and the *Department of Citizenship and Immigration Act*.

SIGNED at on

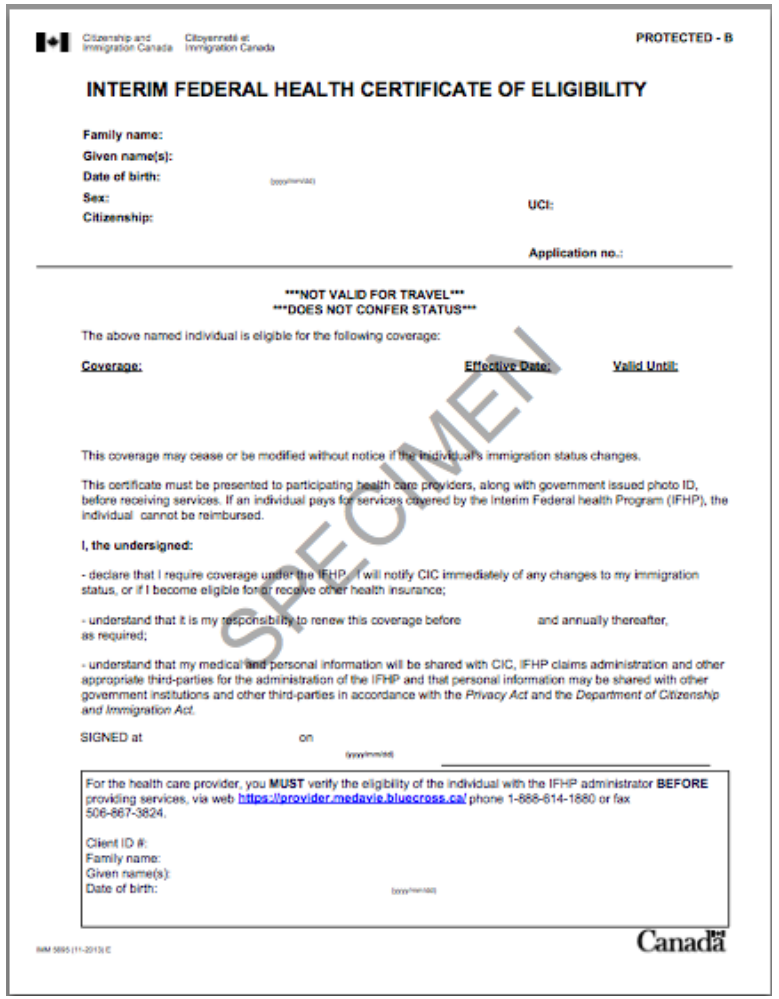
For the health care provider, you **MUST** verify the eligibility of the individual with the IFHP administrator **BEFORE** providing services, via web https://provider.medavie.bluecross.ca/ phone 1-888-614-1880 or fax 506-867-3824.

Client ID #:
Family name:
Given name(s):
Date of birth:

Canada

Health Care Coverage for Refugee Claimants

- IFHP for all services: basic and supplemental



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Client ID #:
Family name:
Given name(s):
Date of birth: (yyyy/mm/dd)

IMM 5695 (11-2013) E

Canada

IFHP Supplemental Coverage

- **Medications:** *Similar to provincial formulary for individuals on social assistance*
- **Dental:** *Emergency exams, x-rays, extractions*
- **Vision:** *Annual eye exam and glasses/lenses every 2 years*
- **Allied health** professional services: *physical therapy, occupational therapy, speech & language, nursing visits, clinical psychologists*
- **Medical devices** and equipment

Changes to IFHP

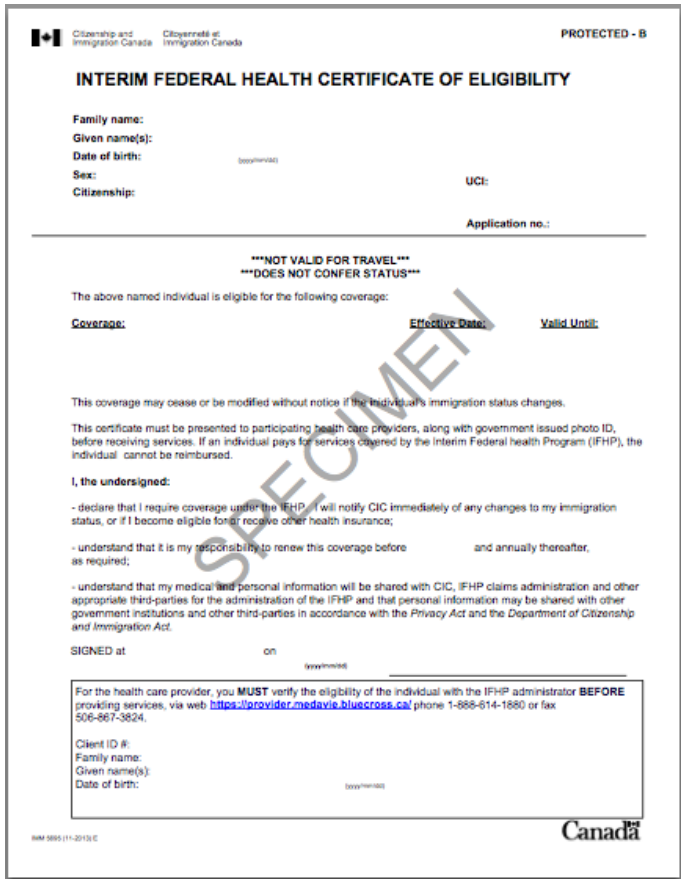
April 2012, the Federal Govt made major cuts to IFH program

- *All refugees lost federal coverage for "supplemental services"*
- *Some lost access to essentially all medical care*

As of April 2016, IFH has been restored to same levels as before 2012

Accessing Supplemental Services

- Show Interim Federal Health Program Certificate
- **Health professionals must be registered with IFHP Medavie Blue Cross, can register on website**



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IMM 5095 (11-2013) E

Canada

Refugee Health

msf.ca

Question

- You see a refugee patient and suggest getting some laboratory tests. The patient declines saying they already received a number of tests on their immigration medical exam.

- Is this true?

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Immigration Medical Exam

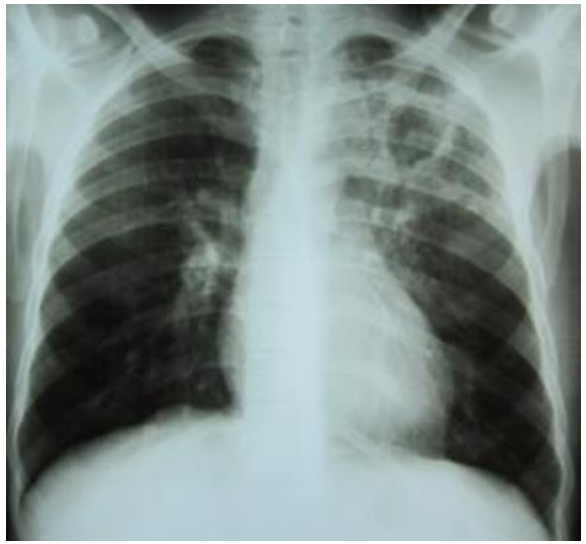
Cursory evaluation of individual's health status that may suggest:

1. a condition that could place an excessive demand on the public health care or social service system in Canada
2. a serious communicable disease

www.unhcr.org

Immigration Health Exam

- History
- Physical exam
- Diagnostics:
  1. Syphilis (≥ 15 years)
  2. CXR (≥ 11 years)
  3. HIV (≥ 15 years)
  4. Urinalysis (≥5 years)



http://www.cic.gc.ca/english/resources/publications/dmp-handbook/index.asp#chap4

Migratory Journey and Health

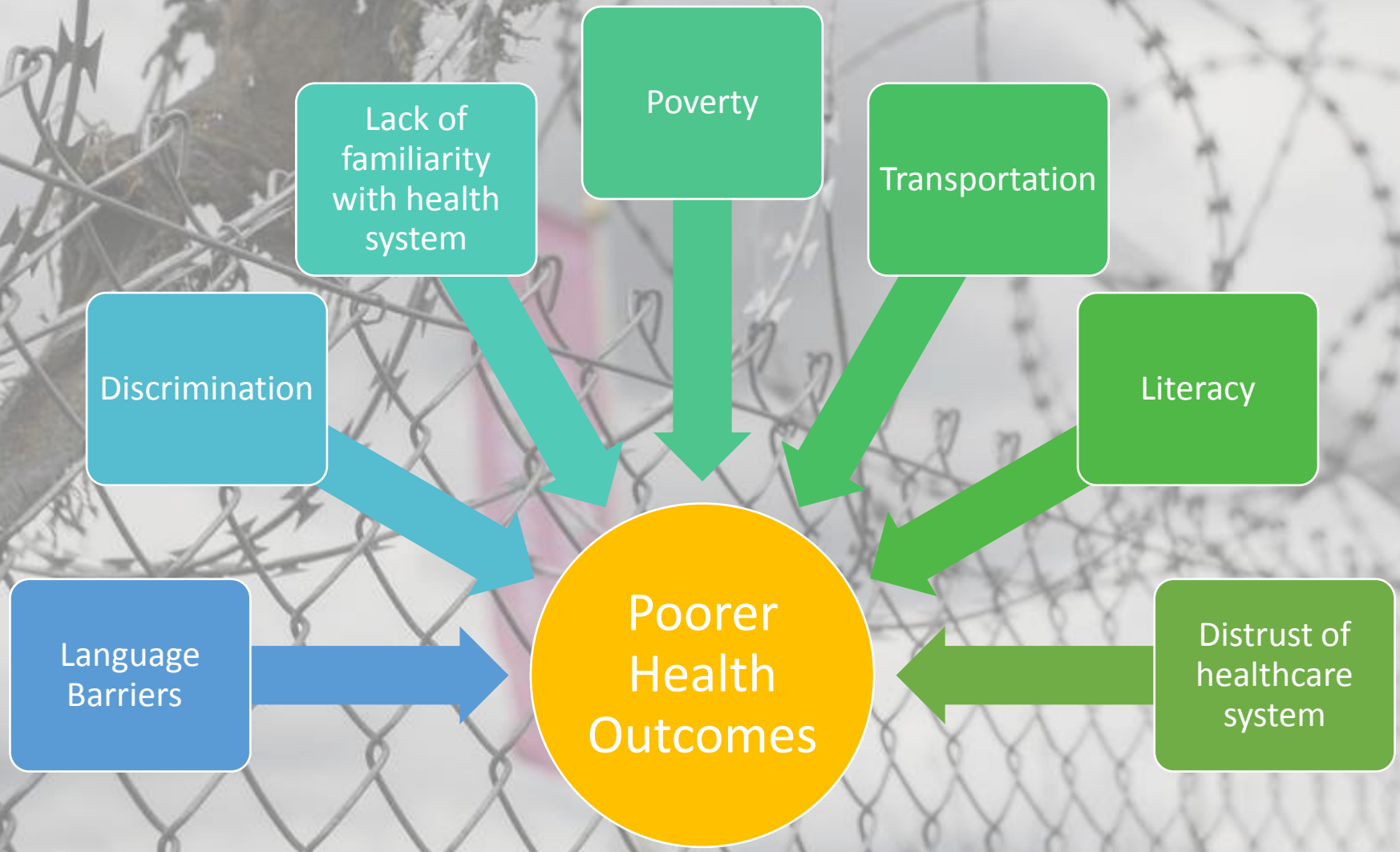
Limited access to care

Poor living conditions (political and social instability, camps)

Exposure to violence and trauma

Dangerous journeys

Barriers to Health Care in Canada for Refugees



GUIDELINES CMAJ

Evidence-based clinical guidelines for immigrants and refugees

Kevin Pottie MD MClSc, Christina Greenaway MD MSc, John Feightner MD MSc, Vivian Welch MSc PhD, Helena Swinkels MD MHSc, Meb Rashid MD, Lavanya Narasiah MD MSc, Laurence J. Kirmayer MD, Erin Ueffing BHSc MHSc, Noni E. MacDonald MD MSc, Ghayda Hassan PhD, Mary McNally DDS MA, Kamran Khan MD MPH, Ralf Buhrmann MDCM PhD, Sheila Dunn MD MSc, Arunmozhi Dominic MD, Anne E. McCarthy MD MSc, Anita J. Gagnon MPH PhD, Cécile Rousseau MD, Peter Tugwell MD MSc; and coauthors of the Canadian Collaboration for Immigrant and Refugee Health

CMAJ 2011. DOI:10.1503/cmaj.090313

Initial Intake of Refugees at Crossroads Clinic

History
Physical exam

Infectious Disease Screening

- Hepatitis B and C (depending on region)
- Syphilis
- HIV
- Gonorrhea/chlamydia
- Varicella serology (≥13yo) *
- TB skin test
- Serology for schistosomiasis (Africa+) and strongyloides (SE Asia, Africa) *

Chronic Disease Screening

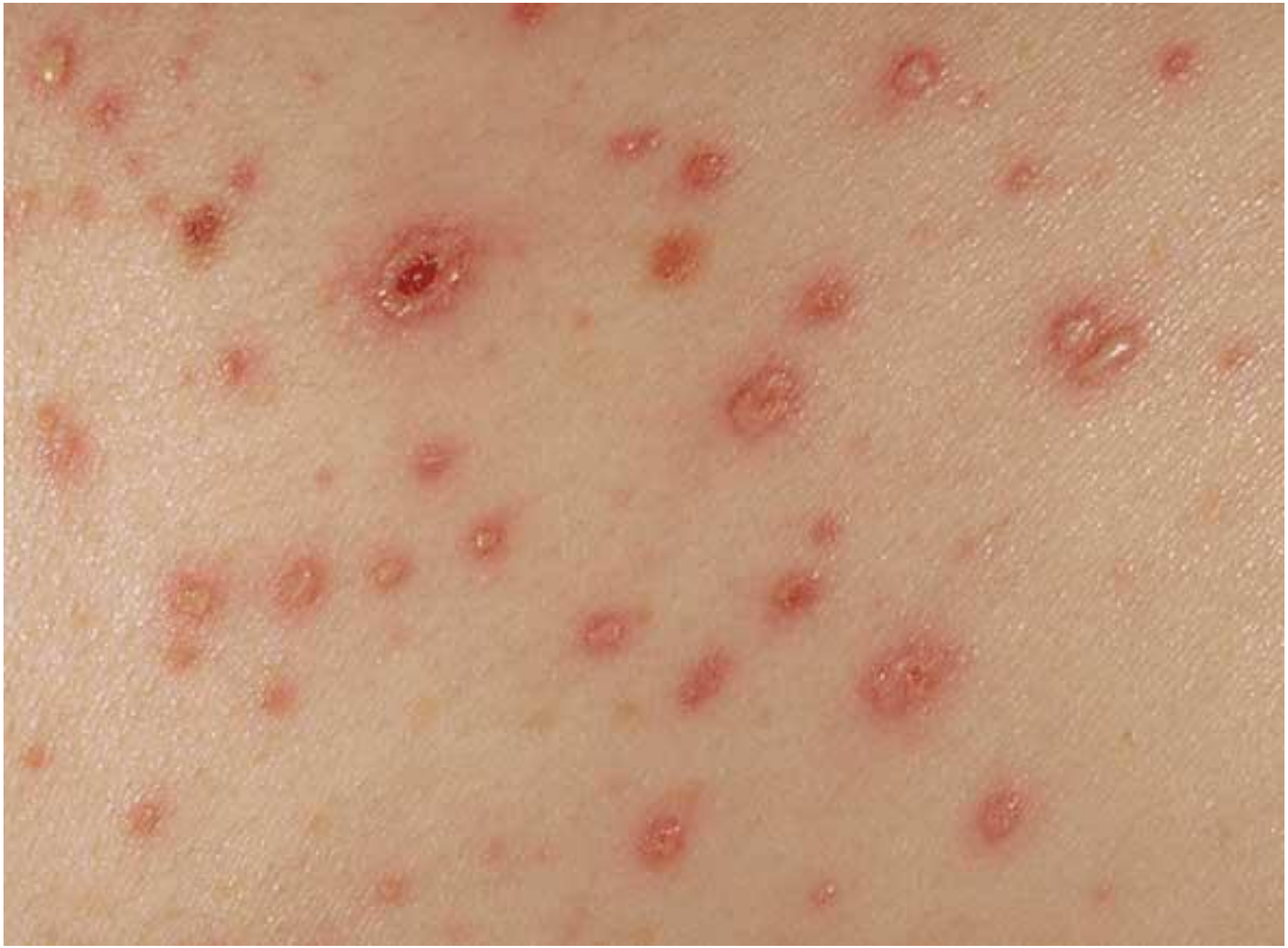
- Anemia: CBC
- Cancer screening including PAP testing
- Age-appropriate DM screening and lipids

Immunizations *

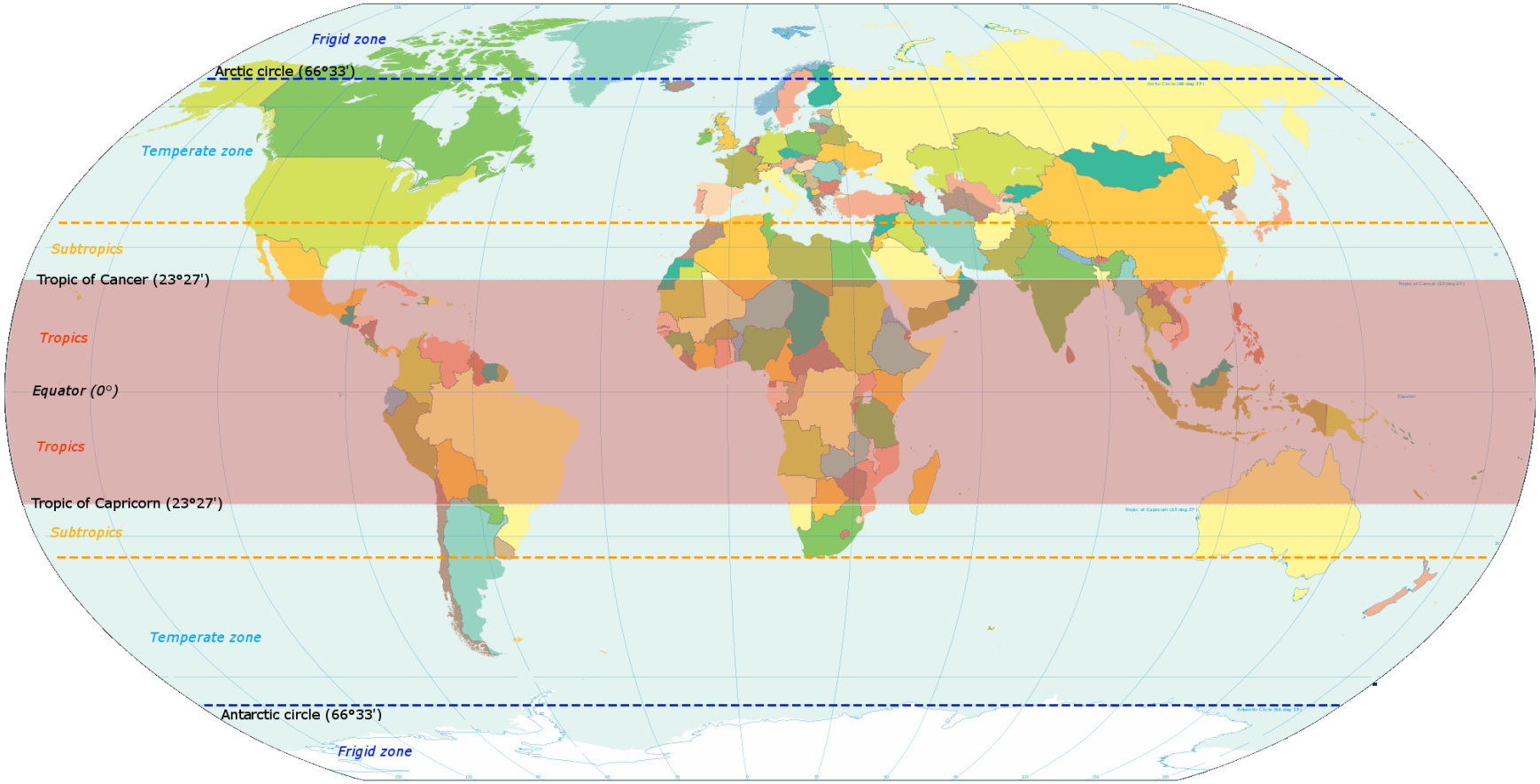
Women's Health *

Mental health *

Adapted from Pottie et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ* 2011;183(12): E284-E925

- 

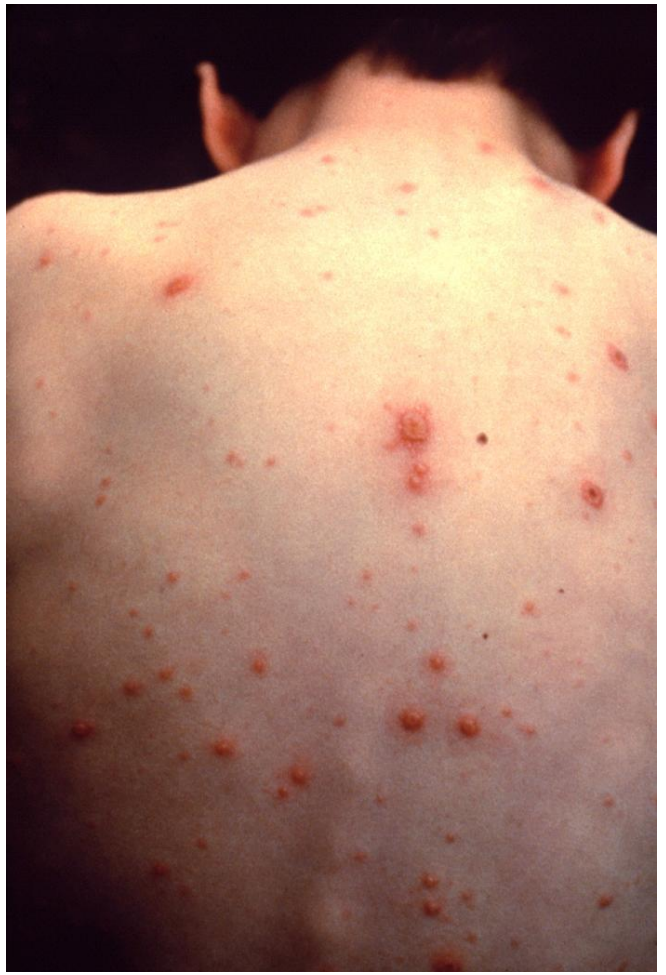
In a Temperate Climate…



Varicella is childhood disease, less than 5% of adults are likely susceptible…But where do the majority of refugees come from?

Varicella

- One of rare infectious diseases more common in temperate areas
- Mortality 20-40X higher in adults vs children
- Check serology in those ≥13yo and vaccinate non-immune *

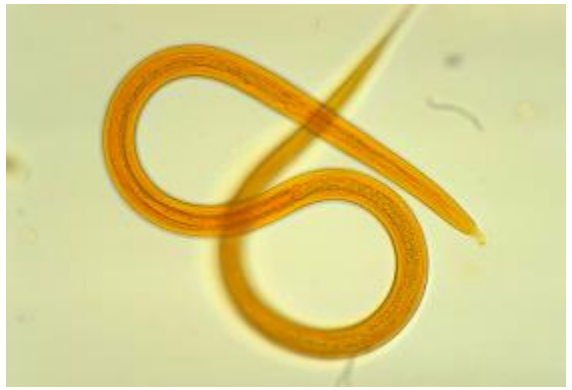


phil.cdc.gov

Pottie et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ* 2011;183(12): E284-E925

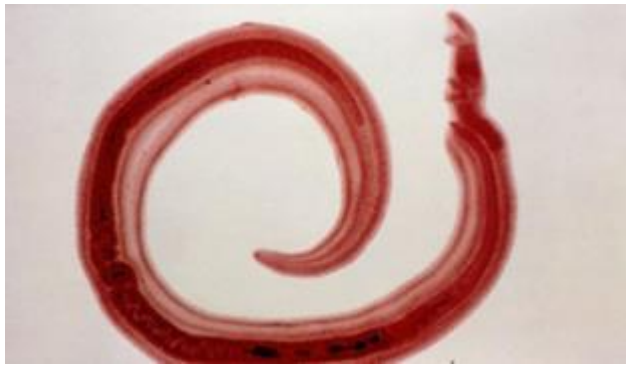
Parasites

- **Strongyloides:**
  - Risk of Disseminated Strongyloides Infection if immunosuppressed

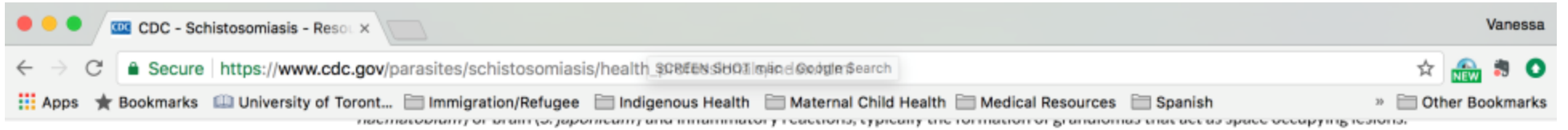


www.refugeehealth.ca

- **Schistosomiasis**
  - Hepatic/ gastrointestional or urinary tract complications



www.nhs.ulk



Back to Top

Treatment

Infections with all major *Schistosoma* species can be treated with praziquantel. The timing of treatment is important since praziquantel is most effective against the adult worm and requires the presence of a mature antibody response to the parasite. For travelers, treatment should be at least 6-8 weeks after last exposure to potentially contaminated freshwater. One study has suggested an effect of praziquantel on schistosome eggs lodged in tissues. Limited evidence of parasite resistance to praziquantel has been reported based on low cure rates in recently exposed or heavily infected populations; however, widespread clinical resistance has not occurred. Thus, praziquantel remains the drug of choice for treatment of schistosomiasis. Host immune response differences may impact individual response to treatment with praziquantel. Although a single course of treatment is usually curative, the immune response in lightly infected patients may be less robust, and repeat treatment may be needed after 2 to 4 weeks to increase effectiveness. If the pre-treatment stool or urine examination was positive for schistosome eggs, follow up examination at 1 to 2 months post-treatment is suggested to help confirm successful cure.

***Schistosoma* species infection**	**Praziquantel dose and Duration**
Schistosoma mansoni, S. haematobium, S. intercalatum	40 mg/kg per day orally in two divided doses for one day
S. japonicum, S. mekongi	60 mg/kg per day orally in three divided doses for one day

There is a lack of safety trial data for the use of praziquantel in children less than 4 years of age or pregnant women. However, this drug has been distributed widely in mass drug administration programs and WHO now recommends that pregnant women should be treated as part of those campaigns based on extensive experience with the drug and review of the veterinary and human evidence. Similarly, WHO reports that there is growing evidence that infected children as young as 1 year old can be effectively treated with praziquantel without serious side effects; however, the drug is commonly available in the form of large, hard-to-swallow pills, which puts young children at risk for choking and other difficulties swallowing the drug.

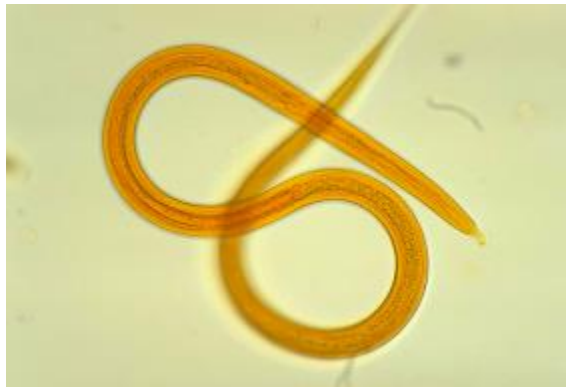
Back to Top

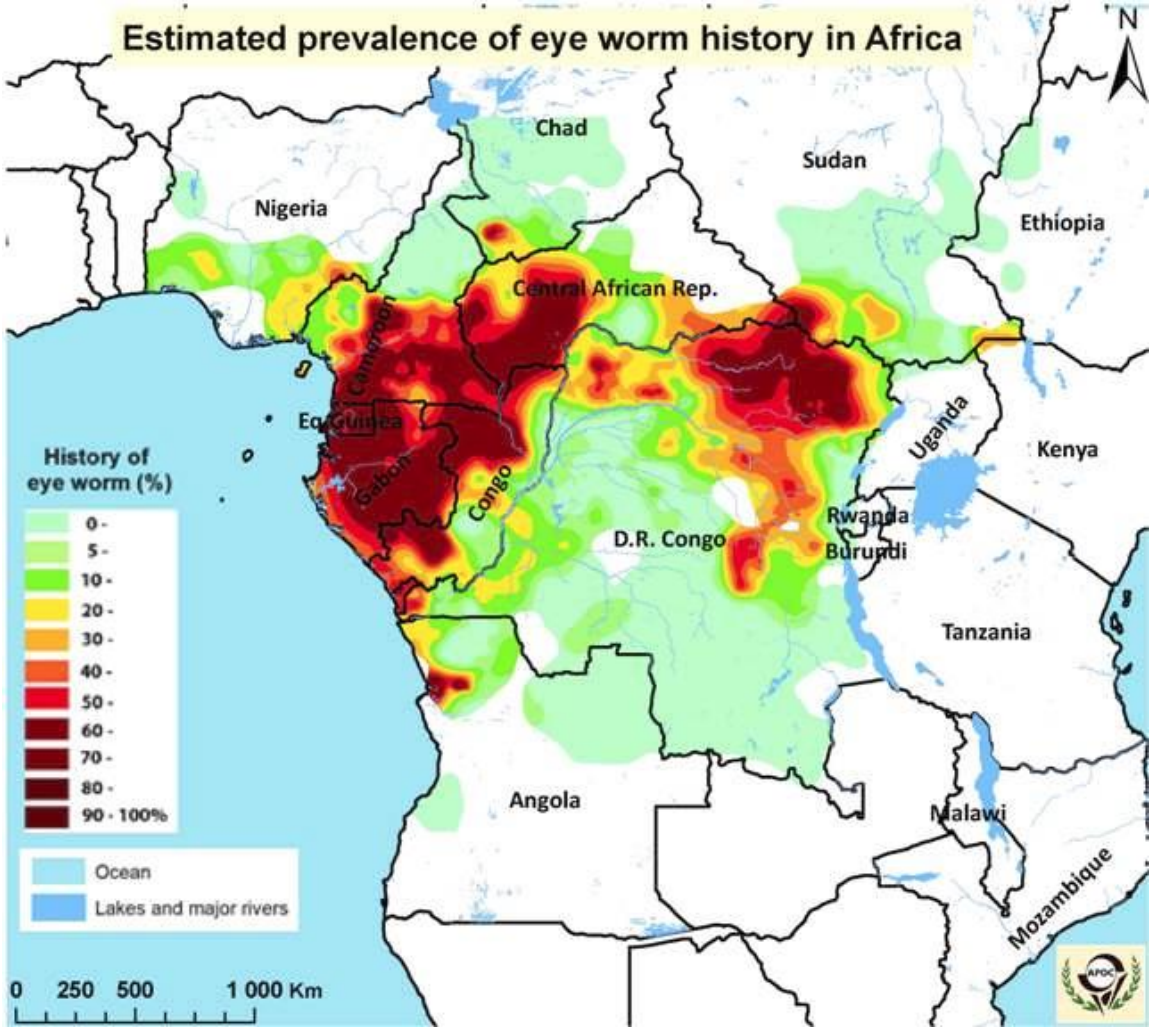
Parasite Treatment

- **Strongyloides****
  - Ivermectin
    200µg/kg x 2 days

OR

  - Albendazole
    400 mg BID x7 days





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Mental health

Adapted from Pottie et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ* 2011;183(12): E284-E925

Vaccinations

- Adacel polio 0, 2, 6months after 2nd dose
- MMR 2 doses, 4 weeks apart (When CD4 > 200)
- Varicella 2 doses, 6weeks -3months apart (When CD4 > 200)
- HepB 0,1, 6months

<u>HIGH risk:</u>

- Prevnar 1 dose, Pneumovax 23 8 weeks later.
  - Pneumovax 5yrs later; last dose at 65yrs.
- Menactra 0, 2months, booster q 5yrs
- Hep A immunization 0, 6months
- HPV Vaccine 0, 2, 6months if can access

Women's Health

- **Unmet contraceptive needs**
  - Screen early and often, address stigma/fears, provide education
- **Conception and future pregnancy planning opportunities**
- **Cervical cancer screening/pap**
  - Even in those > 70 yrs without pap hx
  - *But generally not at initial visit*
  - *ANNUAL* pap screening in our HIV + patient population
  - Abnormal cytology rates higher in 10X higher in HIV+ women with lower CD4 counts

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Mental Health Issues in Refugees

What are the rates of PTSD in refugee populations?

unhcr.org

Trauma and PTSD Symptoms in Rwanda
Implications for Attitudes Toward Justice and Reconciliation

Phuong N. Pham, PhD, MPH
Harvey M. Weinstein, MD, MPH
Timothy Longman, PhD

Context The 1994 genocide in Rwanda led to the loss of at least 10% of the country's 7.7 million inhabitants, the destruction of much of the country's infrastructure, and the displacement of nearly 4 million people. In seeking to rebuild societies such as Rwanda, it is important to understand how traumatic experience may shape the ability of individuals and groups to respond to judicial and other reconciliation initiatives.

Objectives To assess the level of trauma exposure and the prevalence of posttraumatic stress disorder (PTSD) symptoms and their predictors among Rwandans and to

2074 respondents:

75.4% were forced to flee their homes
73.0% had a close member of their family killed
70.9% had property destroyed or lost.

24.8% met symptom criteria for PTSD

From April to mid July 1994, an unprecedented wave of organized violence swept across the

the breakdown of any semblance of civility.[1,2]

The principal response by diplomats and the human rights community to prevent future violence and promote reconciliation in postconflict societies has been to hold perpetrators accountable by establishing legal mechanisms to try those accused of human rights violations.[4] In November 1994, the International Criminal Tribunal for Rwanda (ICTR) was charged with trying the organizers of the 1994 genocide. The majority of those accused of participation in the Rwandan genocide, however, will be tried by national courts. Yet the clas-

met PTSD symptom criteria were less likely to have positive attitudes toward the Rwandan national trials (OR, 0.77; 95% CI, 0.61-0.98), belief in community (OR, 0.76; 95% CI, 0.60-0.97), and interdependence with other ethnic groups (OR, 0.71; 95% CI, 0.56-0.90). Respondents with exposure to multiple trauma events were more likely to have positive attitudes toward the ICTR (OR, 1.10; 95% CI, 1.04-1.17) and less likely to support the Rwandan national trials (OR, 0.90; 95% CI, 0.84-0.96), the local gacaca trials (OR, 0.80; 95% CI, 0.72-0.89), and 3 factors of openness to reconciliation: belief in nonviolence (OR, 0.92; 95% CI, 0.87-0.97), belief in community (OR, 0.92; 95% CI, 0.87-0.98), and interdependence with other ethnic groups (OR, 0.86; 95% CI, 0.81-0.92). Other variables that were associated with attitudes toward judicial processes and openness to reconciliation were educational level, ethnicity, perception of change in poverty level and access to security compared with 1994, and ethnic distance.

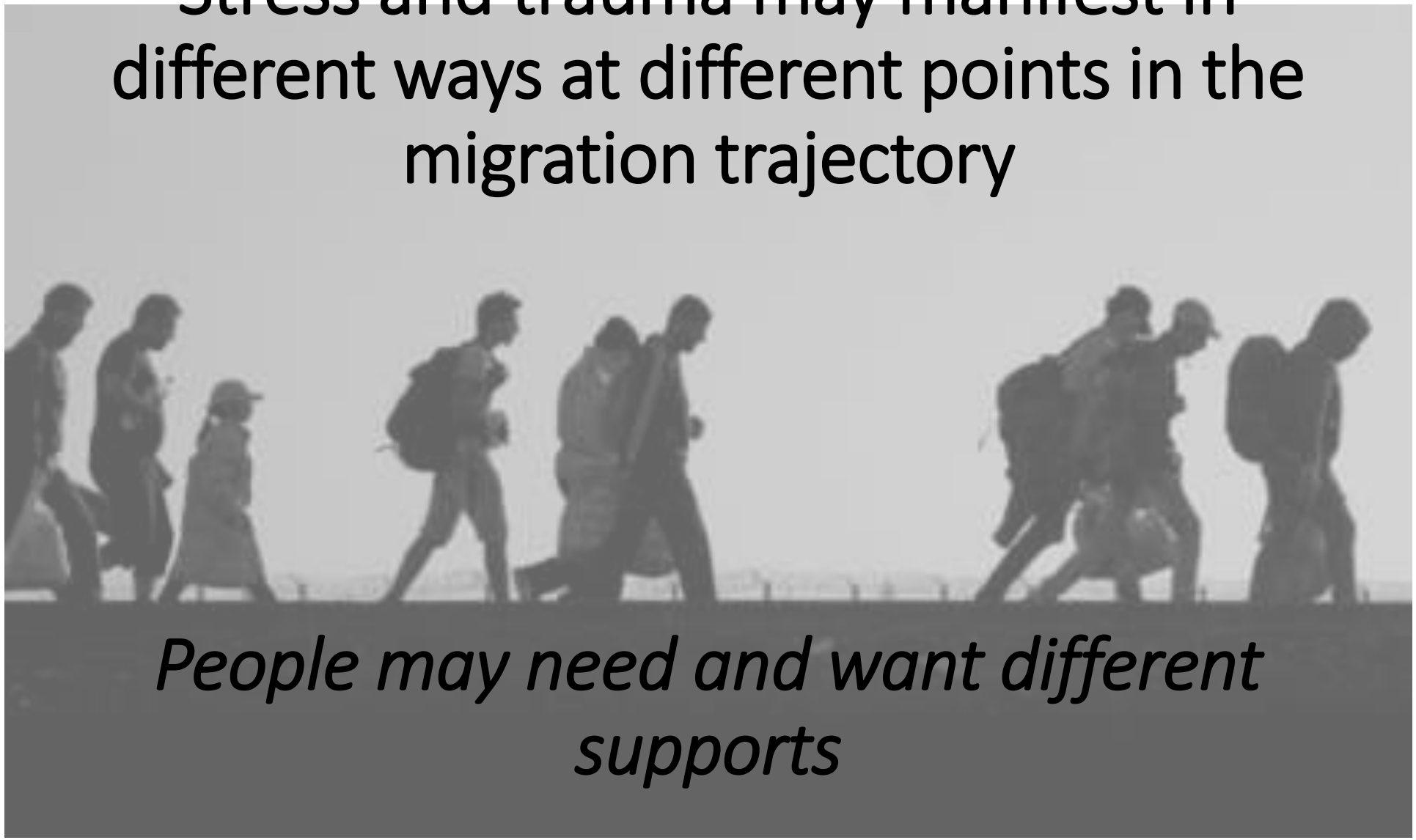
Conclusions This study demonstrates that traumatic exposure, PTSD symptoms, and other factors are associated with attitudes toward justice and reconciliation. Societal interventions following mass violence should consider the effects of trauma if reconciliation is to be realized.

JAMA. 2004;292:602-612 www.jama.com

Exposure to trauma does not necessarily lead to post-traumatic stress disorder

unhcr.org

Stress and trauma may manifest in different ways at different points in the migration trajectory



People may need and want different supports

Do NOT specifically screen for exposure to trauma

- *May cause more harm than benefit in well-functioning individuals*

- *Be alert for somatic symptoms and functional impairments that may signal underlying mental health issues*

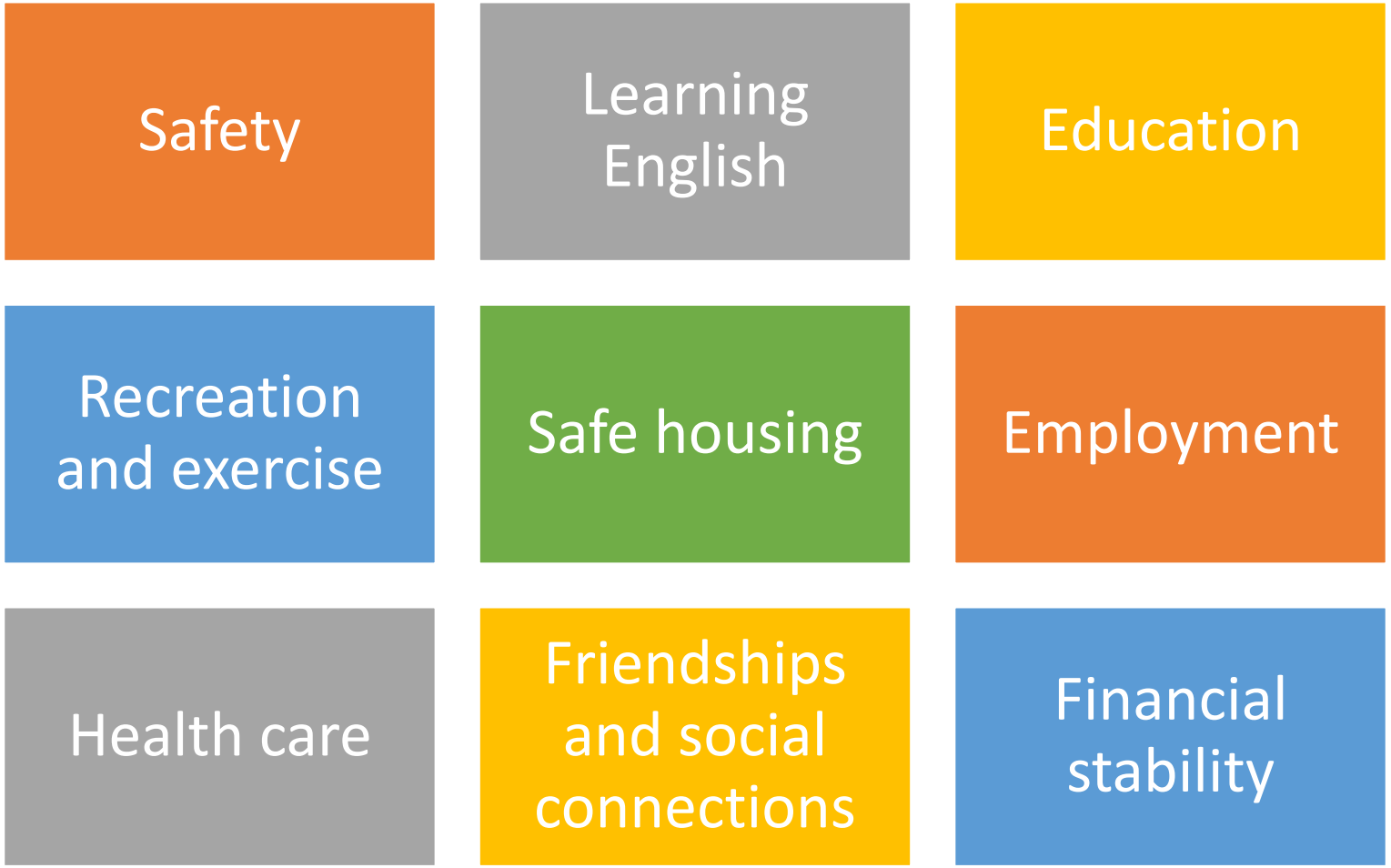
Pottie et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ* 2011;183(12): E284-E925

Mental health strongly influenced by conditions of migration and resettlement

Prioritize resilience promotion over illness management

Focus on meeting social concerns

Promoting Resilience



Community Partnerships

Rethinking “Cultural Competence”

- Trusting relationships
- Respectful inquiry and deep listening
- Appreciation of diversity across and *within* cultures
- Questioning stereotypes/biases
- Humility, curiosity
- **Compassion**

unhcr.org

“While every refugee's story is different and their anguish personal, they all share a common thread of uncommon courage – the courage not only to survive, but to persevere and rebuild their shattered lives.”

Antonio Guterres, U.N. High Commissioner for Refugees, 2005

unhcr.org

Helpful Websites

- Canadian Collaboration for Immigrant and Refugee Health: www.ccirhken.ca
- www.refugeehealth.ca
- Canadian Pediatrics Society: www.kidsnewtocanada.ca
- CAMH Refugee Health Project: https://www.porticonetwork.ca/web/rmhp
- Ontario Settlement services/info: www.settlement.org
- Community resources: www.211toronto.ca
- CDC for infectious disease info

Thank you!

Questions?

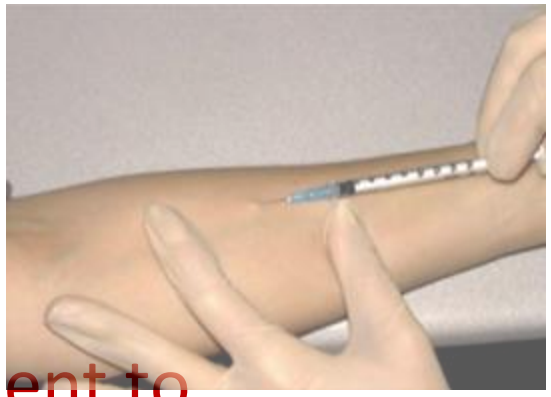
Photo: UNHCR.org

Post-Migration and Well-Being

- Uncertain immigration status
- Communication/language gaps
- Employment/financial stressors
- Poverty
- Housing instability
- Separation from family and ongoing insecurity
- Loss of social status
- Acculturation
- Gender and family role changes
- Social Isolation
- Discrimination, racism
- Unmet expectations

Latent TB Infection

- Test all refugees ≤50 yo from areas of high endemicity (smear positive pulm TB >15/100,000)
  - Especially important in children and in those with risk factors for reactivation
  - Consider in >50yo at high risk
- Differentiate latent from active TB
  - **IME does NOT screen for LTBI**



- Test for LTBI only if there is a commitment to treat if results are positive

Table 1. Risk factors for the development of active tuberculosis among people with a positive tuberculin skin test (presumed infected with *Mycobacterium tuberculosis*)

Risk factor	Estimated risk for TB relative to people with no known risk factor	Reference number
High risk		
Acquired immunodeficiency syndrome	110-170	5
Human immunodeficiency virus infection	50-110	6,7
Transplantation (related to immune-suppressant therapy)	20-74	8-12
Silicosis	30	13,14
Chronic renal failure requiring hemodialysis	10-25	15-18
Carcinoma of head and neck	11.6	19
Recent TB infection (≤2 years)	15.0	20,21
Abnormal chest x-ray – fibronodular disease	6-19	22-24
Moderate risk		
Tumour necrosis factor alpha inhibitors	1.5-45.8	25,26,43
Diabetes mellitus (all types)	2-3.6	27-29
Treatment with glucocorticoids (≥15mg/d prednisone)	4.9-7.7	30
Young age when infected (0-4 years)	2.2-5	31
Slightly increased risk		
Heavy alcohol consumption (≥3 drinks/day)	3-4	32,33
Underweight (<90% ideal body weight; for most people, this is a body mass index ≤20)	2-3	34
Cigarette smoker (1 pack/day)	1.8-3.5	35-38
Abnormal chest x-ray – granuloma	2	24-39
Low risk		
Person with positive TST, no known risk factor, normal chest x-ray ("low risk reactor")	1	40
Very low risk		
Person with positive two-step TST (booster), no other known risk factor and normal chest x-ray	0.5	Extrapolated from 40 and 1

Canadian TB Standard-2013

Table 7A: Relative risk (RR) that active tuberculosis will develop in the presence of underlying medical conditions*

Variable	RR†
High risk (RR > 6‡)	
AIDS	110–170
HIV infection	10–110
Transplantation (related to immunosuppressant therapy)	20–74
Leukemia, lymphoma	1.0–35
Silicosis	1.5–33
Chronic renal failure requiring hemodialysis	1.6–25
Carcinoma of head and neck	16
Recent tuberculosis infection (≤ 2 yr)	15
Abnormal results of chest radiography: fibronodular disease	6–19
Tumour necrosis factor α inhibitors	1.7–9
Intermediate risk (RR = 3–6‡)	
Treatment with glucocorticoids	4.9
Diabetes mellitus (all types)	2.0–4.1
Young when infected (0–4 yr)	2.2–5

Pottie et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ* 2011;183(12): E30

Online TST Calculator

- http://www.tstin3d.com/en/calc.html

Consider:

- Size of induration
- Pre-test probability
- Risk of disease if person is truly infected

Rates of MMR susceptibility

A large study in Montreal examined the prevalence of serological immunity to measles, mumps and rubella in newly arrived immigrants and refugees;

- 36% of participants were susceptible to one of the three diseases

Greenaway C et al. Susceptibility to Measles, Mumps, and Rubella in Newly arrived Adult Immigrants and Refugees. Ann Intern Med. 2007; 146:20-24